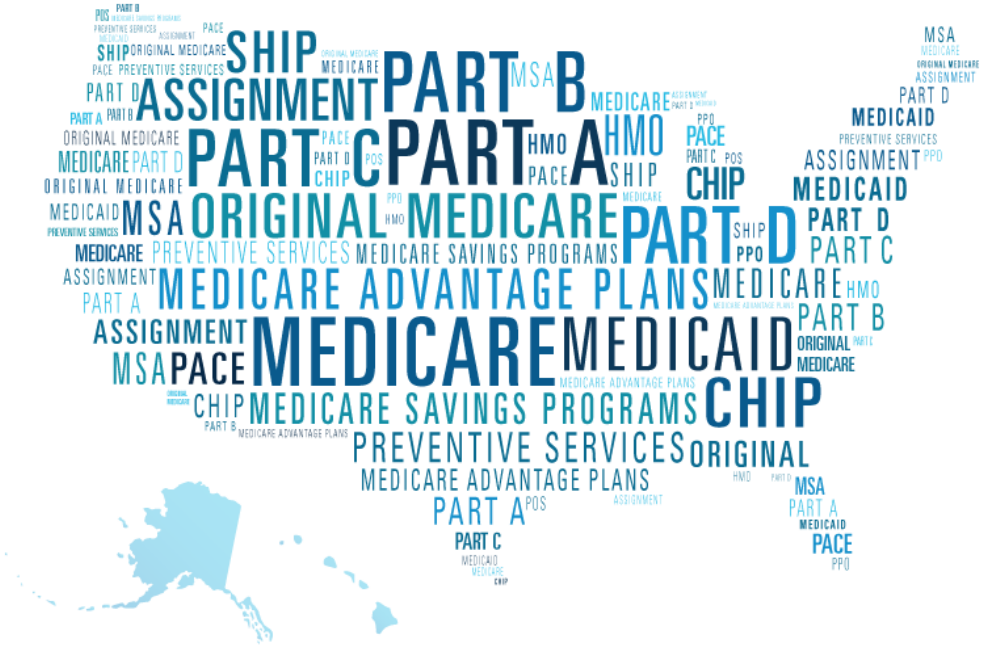
2014 National Training Program

Workbook

Module: 2

Medicare Rights and Protections



DEPARTMENT OF HEALTH & HUMAN SERVICES · USA

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Centers for Medicare & Medicaid Services
National Training Program
Instructor Information Sheet

Module 2 - Medicare Rights and Protections

Module Description

The lessons in this module explain the rights and protections afforded to Medicare beneficiaries whether they are enrolled in Original Medicare, a Medicare Advantage Plan (like a Health Maintenance Organization or Preferred Provider Organization), other Medicare health plan (like a Medicare Cost Plan or Program of All-Inclusive Care for the Elderly), or a Medicare Prescription Drug Plan.

The materials—up-to-date and ready-to-use—are designed for information givers/trainers familiar with the Medicare program who would like to have prepared information for presentations.

Objectives

- Explain Medicare rights and protections
- Summarize Medicare privacy practices
- Locate additional information and resources

Target Audience

This comprehensive module is designed for presentation to trainers and other information givers.

Time Considerations

The module consists of 62 PowerPoint slides with corresponding speaker's notes, activities, and quiz questions. It has a resource guide and National Training Program (NTP) contact slide to reference. It can be presented in 50 minutes. Allow approximately 20 more minutes for discussion, questions, and answers. Additional time may be added for add-on activities.

Course Materials

Materials are self-contained with in the module. This module contains eight Check Your Knowledge questions that give participants the opportunity to apply the module concepts in a real-world setting. Additional slides display as the NTP summary slide with email contact and Appendix. Appendices A–D may be used as full-sized handouts for the Advance Beneficiary Notice of Non-coverage covered in slide 19, and various appeals charts from slides 16, 23, and 37.

Module 2: Medicare Rights and Protections

Contents

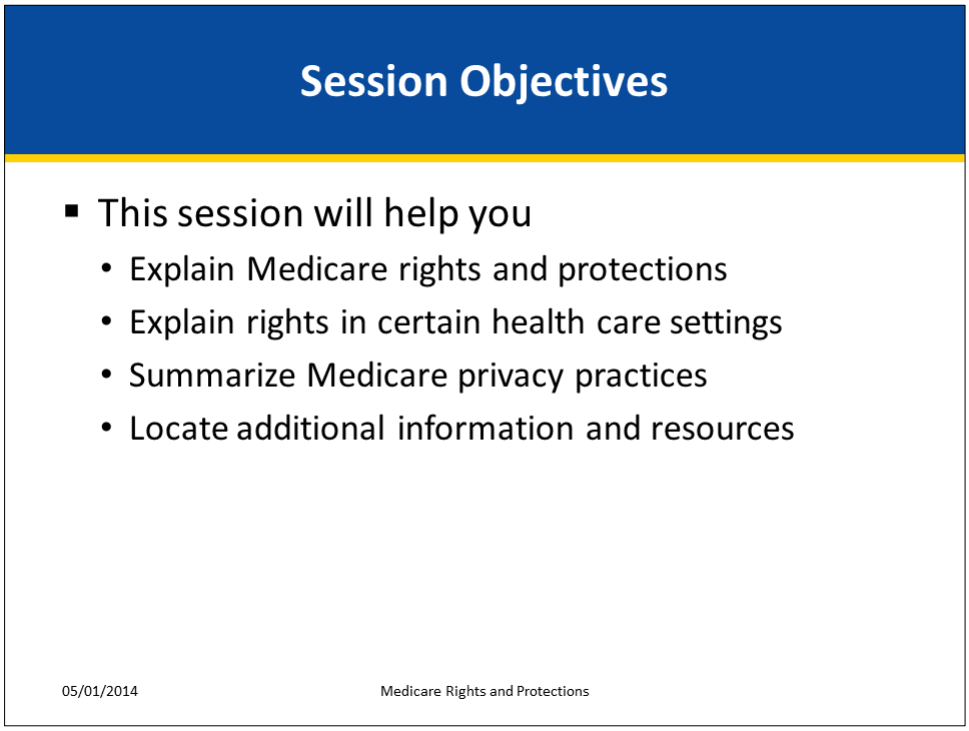
Contents (continued)

Module 2, "Medicare Rights and Protections," explains the rights and protections afforded to you whether you enrolled in Original Medicare, a Medicare Advantage Plan (like a Health Maintenance Organization or Preferred Provider Organization), other Medicare health plan (like a Medicare Cost Plan or Program of All-Inclusive Care for the Elderly), or a Medicare Prescription Drug Plan.

This training module was developed and approved by the Centers for Medicare & Medicaid Services (CMS), the federal agency that administers Medicare, Medicaid, the Children's Health Insurance Program (CHIP), and the Federally-facilitated Health Insurance Marketplace. The information in this module was correct as of May 2014.

To check for an updated version of this training module, visit cms.gov/outreach-and-education/training/cmsnationaltrainingprogram/training-library.html.

This set of CMS National Training Program materials isn't a legal document. Official Medicare program legal guidance is contained in the relevant laws, regulations, and rulings.



This session will help you to understand the rights and protections available to all people with Medicare:

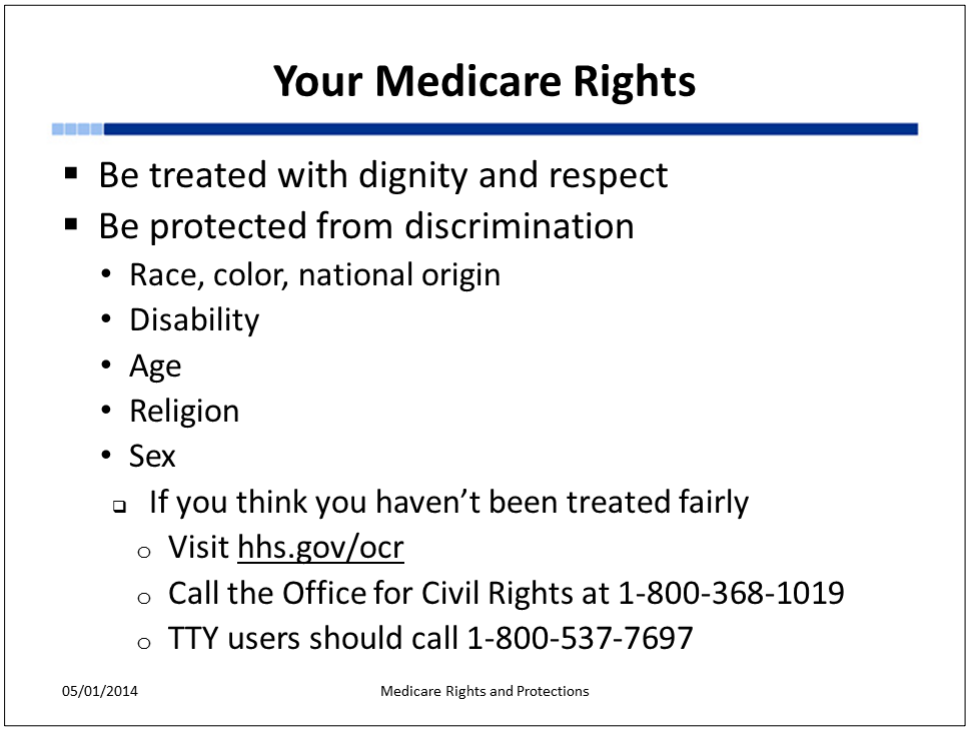
- Explain specific Medicare rights and protections for people with Medicare
- Explain rights in certain health care settings
- Summarize Medicare privacy practices
- Locate additional information and resources

Lesson 1, "Medicare Rights," explains that no matter how you get your Medicare, you have certain guaranteed rights and protections. We'll provide information on additional rights that are specific to how you choose to get your Medicare coverage.

A. Original Medicare
B. Medicare Advantage and other Medicare health plans
C. Medicare Prescription Drug Coverage

Your Medicare rights and protections are designed to

- Protect you when you get health care
- Protect you against unethical practices
- Make sure you get the medically-necessary health care services that the law says you can get
- Protect your privacy

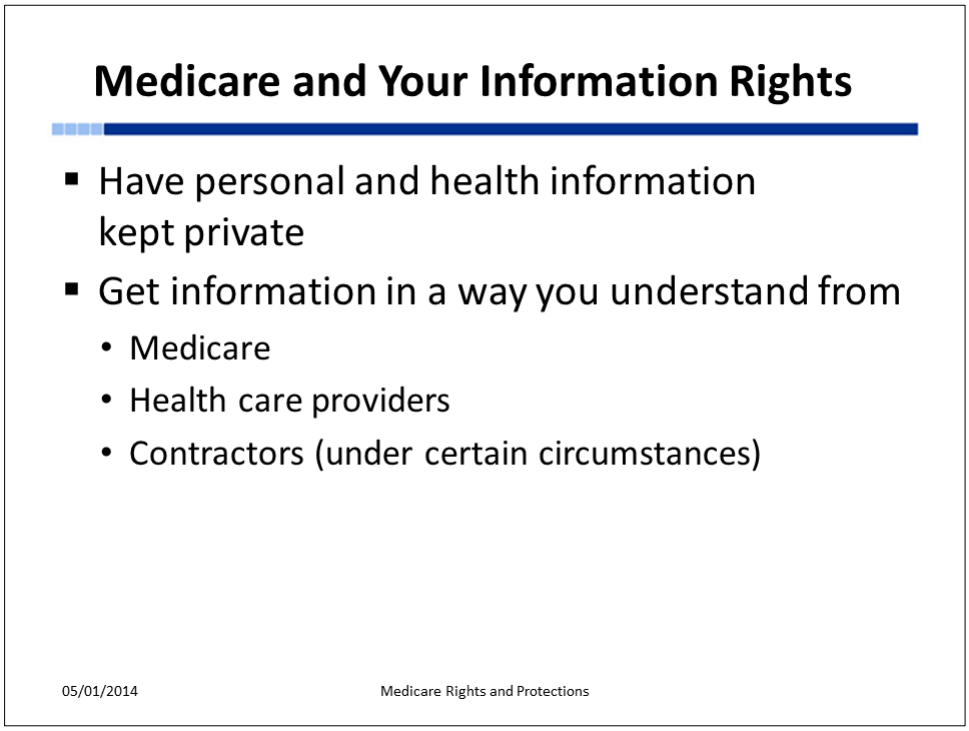


If you have Medicare, you have the following rights:

- To be treated with dignity and respect at all times
- To be protected from discrimination
  - Discrimination is against the law. Every company or agency that works with Medicare must obey the law, and can't treat you differently because of your
    - Race, color, or national origin
    - Disability
    - Age
    - Religion
    - Sex

These protections are generally limited to complaints of discrimination filed against providers of health care and social services who receive federal financial assistance.

If you think you haven't been treated fairly for any of these reasons, call the U.S. Department of Health and Human Services, Office for Civil Rights, at 1-800-368-1019, or visit hhs.gov/ocr. TTY users should call 1-800-537-7697.



If you have Medicare, you have the following rights:

- To have your personal and health information kept private.
  - To learn more about this right
    - ❑ If you have Original Medicare, see the "Notice of Privacy Practices for Original Medicare" in your "Medicare & You" handbook. To view or download, visit medicare.gov/pubs/pdf/10050.pdf (you may also order a copy).
    - ❑ If you have a Medicare Advantage Plan, other Medicare health plan, or a Medicare Prescription Drug Plan, read your plan materials.
- To get information in a way you understand from
  - Medicare
  - Health care providers
  - Under certain circumstances, contractors

If you have Medicare, you have the following rights:

- To get understandable information about Medicare to help you make health care decisions, including: what is covered, what Medicare pays, how much you have to pay, and what to do if you want to file a complaint or an appeal.
- To have your Medicare questions answered.
- Visit medicare.gov.
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.
    - Call your State Health Insurance Assistance Program (SHIP). To get the most up-to-date SHIP phone numbers, visit medicare.gov/contacts, or call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

Need more information?

Call your plan if you're in a Medicare Advantage Plan, other Medicare health plan, or a Medicare Prescription Drug Plan and you have questions about how they cover items, services, or medications.

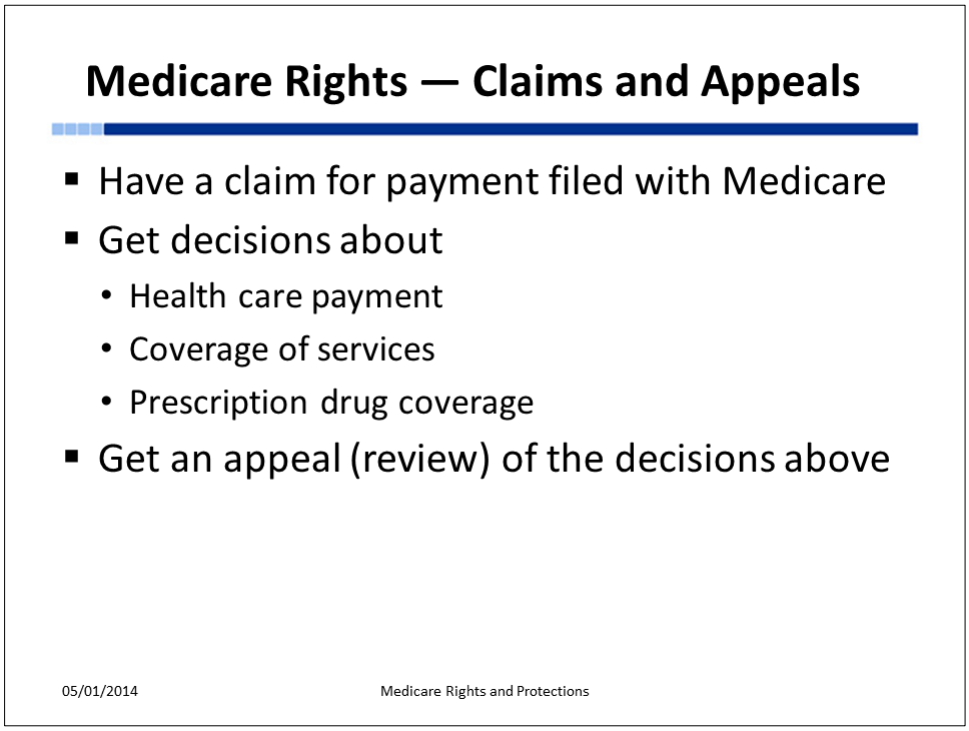
If you have Medicare, you have the following rights:

- To have access to doctors, specialists, and hospitals.
- To learn about your treatment choices in clear language that you can understand, and participate in treatment decisions. If you can't fully participate in your treatment decisions, ask a family member, friend, or anyone you trust to help you make a decision about what treatment is right for you.
- To get health care services in a language you understand and in a culturally-sensitive way.
  - For more information about getting health care services in languages other than English, visit hhs.gov/ocr, or call the Office for Civil Rights at 1-800-368-1019. TTY users should call 1-800-537-7697.
- To get emergency care when and where you need it.
  - If your health is in danger because you have a bad injury, sudden illness, or an illness quickly gets worse, call 911. You can get emergency care anywhere in the United States.

Need more information?

To learn about Medicare coverage of emergency care

- In Original Medicare, call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.
- In a Medicare Advantage Plan or other Medicare health plan, review your plan materials.



If you have Medicare, you have the following rights:

- To have a claim for payment filed with Medicare and get a decision about health care payment, coverage of services, or prescription drugs, even when your doctor says that Medicare won't pay for a certain item or service.
  - When a claim is filed, you get a notice from Medicare letting you know what will and won't be covered. This might be different from what your doctor says. If you disagree with Medicare's decision on your claim, you have the right to appeal.
- To appeal if you disagree with a decision about your health care payment, coverage of services, or prescription drug coverage.
  - For more information about appeals, visit medicare.gov/appeals.
  - For help with filing an appeal, call the State Health Insurance Assistance Program (SHIP) in your state. To get the most up-to-date SHIP phone numbers, visit medicare.gov/contacts or call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.
  - If you have a Medicare Advantage Plan, other Medicare health plan, or a Medicare Prescription Drug Plan, read your plan materials.

If you have Medicare, you have the following rights:

- To file complaints (also called grievances) about services you got, other concerns or problems you have in getting health care, and the quality of the health care you received.
- If you're concerned about the quality of care you're getting
  - In Original Medicare, call the Quality Improvement Organization (QIO) in your state to file a complaint. Visit medicare.gov/contacts to get your QIO's phone number, or call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.
  - In a Medicare Advantage or other Medicare health plan, call the QIO, your plan, or both. If you have End-Stage Renal Disease (ESRD) and have a complaint about your care, call the ESRD network in your state. To get the phone number, visit medicare.gov/contacts or call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

Check Your Knowledge—Question 1

All people with Medicare have the right to be protected from discrimination based on race, color, national origin, disability, age, sex and which of the following?

a. Religion
b. Where they live
c. Their language

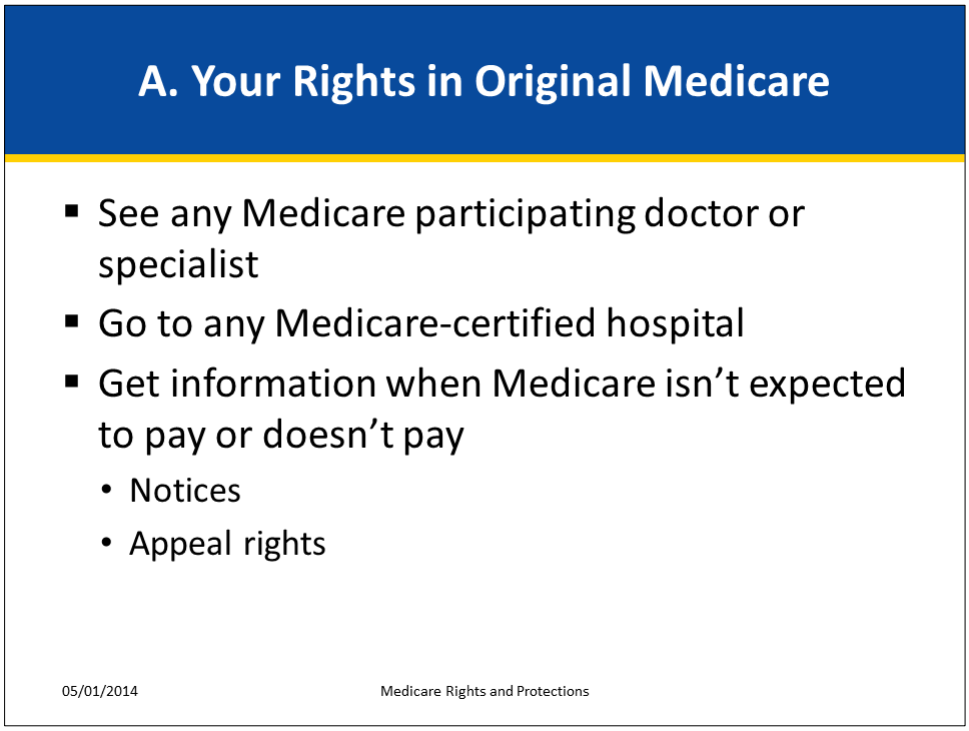
Refer to page 67 to check your answers.

Check Your Knowledge—Question 2

An appeal and a grievance are the same thing.

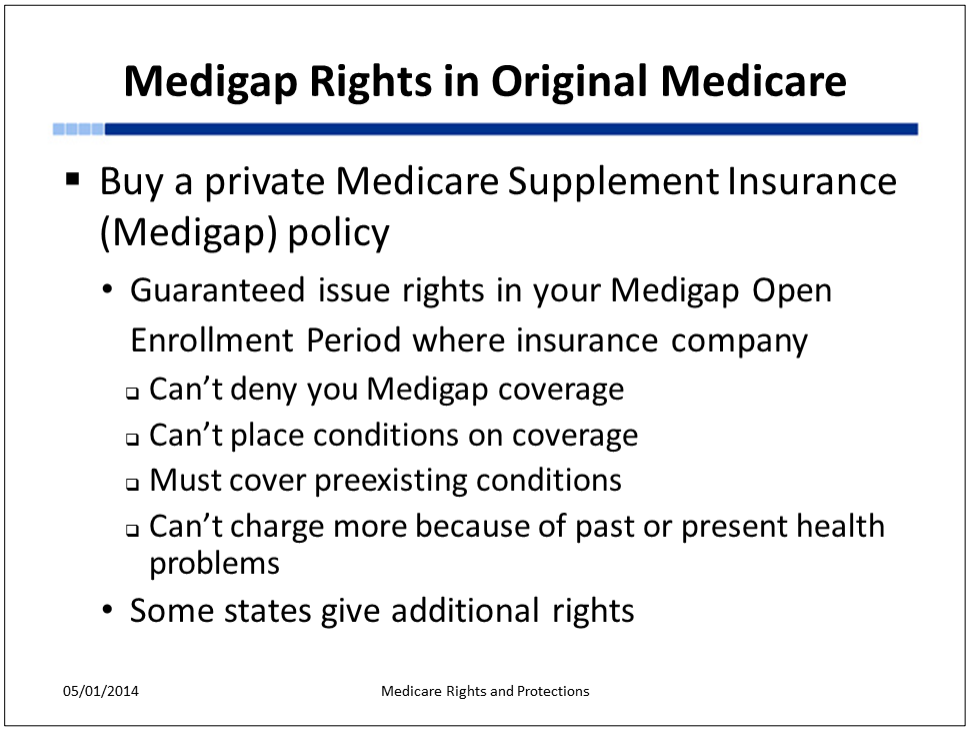
a. True
b. False

Refer to page 67 to check your answers.



Your rights when you are enrolled in Original Medicare include the following:

- The right to see any Medicare participating doctor or specialist (including women's health specialists)
- Go to any Medicare-certified hospital
- Get certain information, such as notices and appeal rights, that helps you resolve issues when Medicare isn't expected to pay or doesn't pay for health care



Your rights when you are enrolled in Original Medicare include the following:

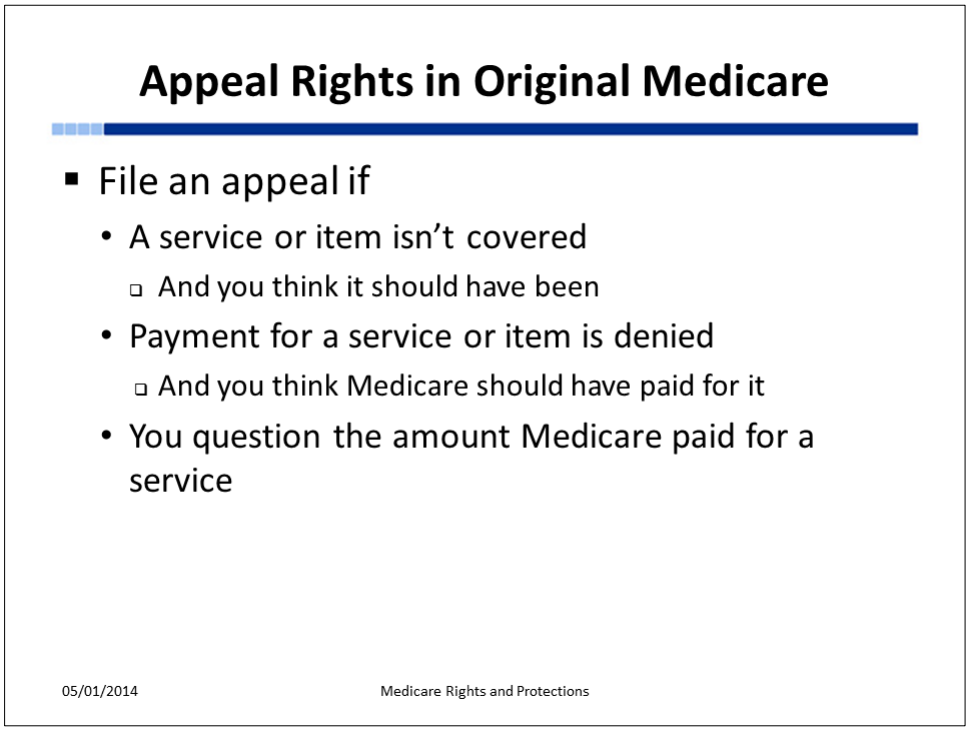
- Buy a Medicare Supplement Insurance (Medigap) policy
  - In some situations, you have the right to buy a Medigap policy. A Medigap policy is a health insurance policy sold by private insurance companies to fill the gaps in Original Medicare coverage, such as coinsurance amounts.
  - Medigap policies must follow federal and state laws that protect you. The front of the Medigap policy must clearly identify it as "Medicare Supplement Insurance."
  - Medigap insurance companies in most states (except Massachusetts, Minnesota, and Wisconsin) can only sell you a "standardized" Medigap policy. These policies are identified by the letters A, B, C, D, F, G, K, L, M, and N.
    - The benefits in any Medigap plan identified with the same letter are the same regardless of which insurance company you purchase your policy from.
  - You have the right to buy a Medigap policy during your Medigap open enrollment period. While the insurance company can't make you wait for your coverage to start, it may be able to make you wait for coverage of a preexisting condition.

When you have guaranteed issue rights, the Medigap plan

- Can't deny you Medigap coverage or place conditions on your policy
- Must cover you for preexisting conditions
- Can't charge you more for a policy because of past or present health problems

Some states offer additional rights to purchase Medigap policies.

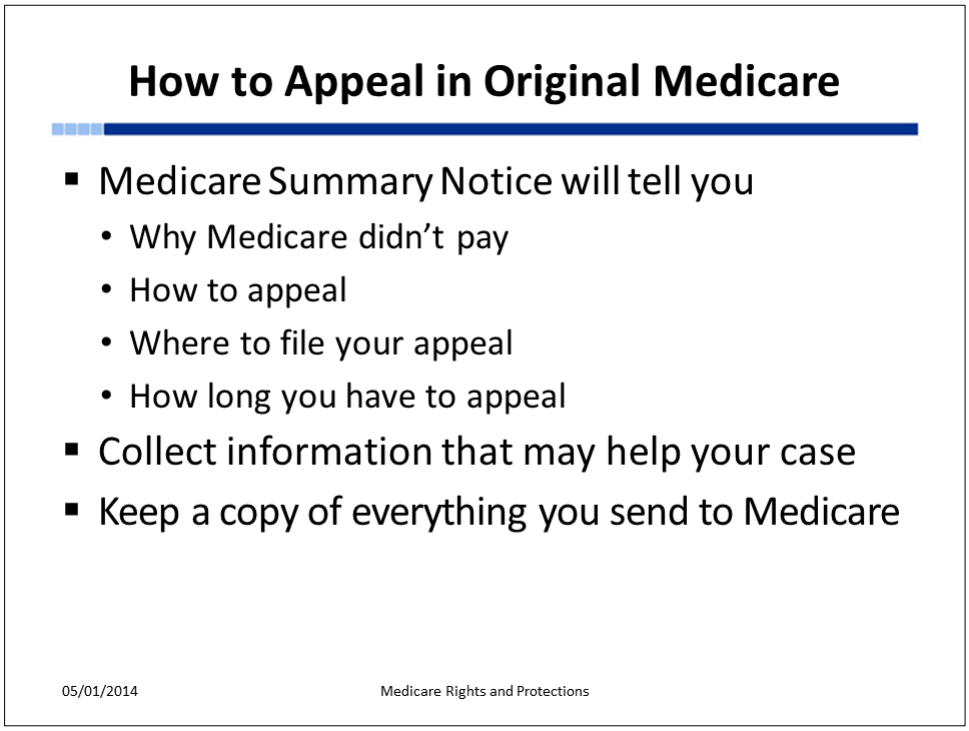
NOTE: Module 3, "Medigap (Medicare Supplement Insurance)" describes these situations.



In Original Medicare, you have the right to a fair, timely, and efficient appeals process.

You can file an appeal if

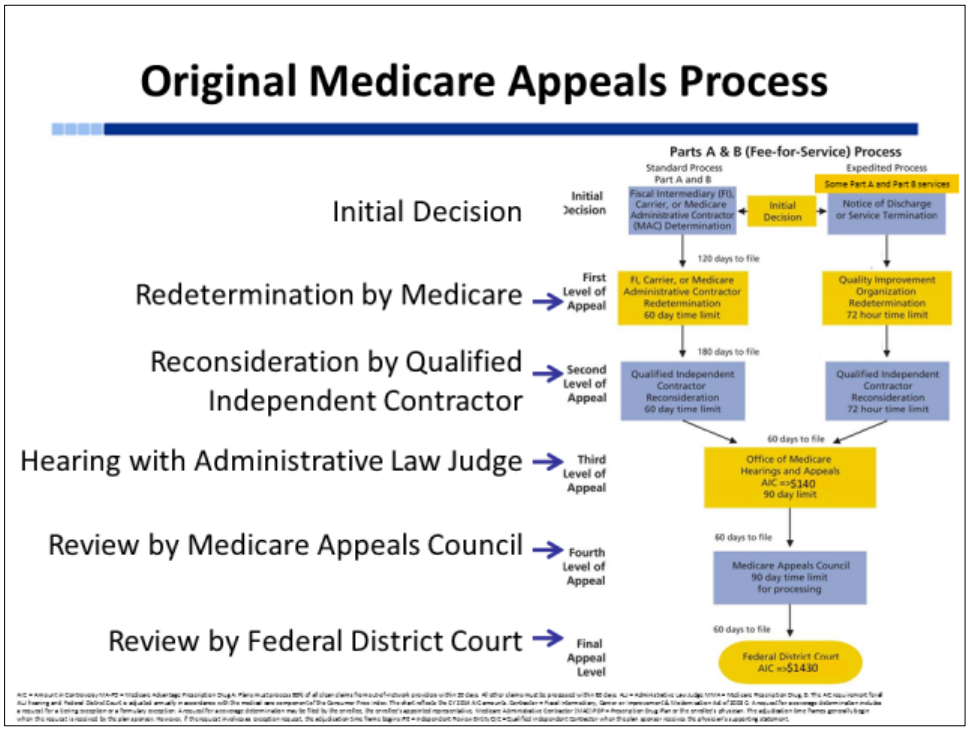
- A service or item you got isn't covered and you think it should have been
- Payment for a service or item is denied and you think Medicare should have paid for it
- You question the amount that Medicare paid for a service



In Original Medicare, when providers and suppliers bill Medicare, you'll get a Medicare Summary Notice. This notice will tell you

- Why Medicare didn't pay
- How to appeal
- Where to file your appeal
- How much time you have to file an appeal

If you decide to appeal, ask your doctor, health care provider, or durable medical equipment supplier for any information that may help your case. Keep a copy of everything you send to Medicare as part of your appeal.

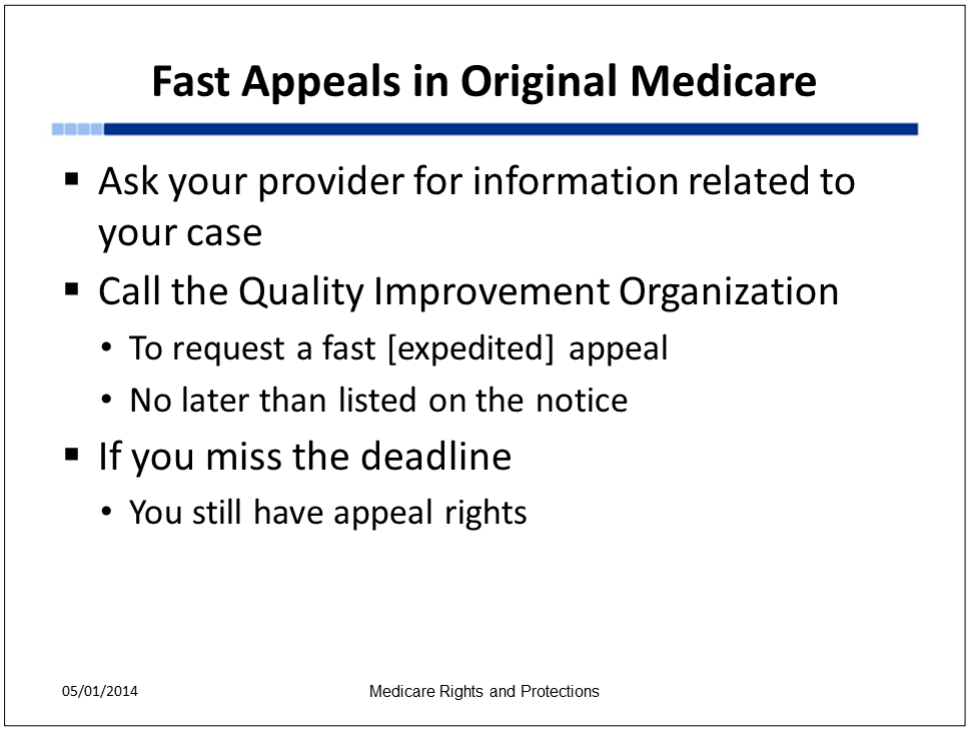


There are five levels in the appeals process in Original Medicare. Look at the job aid section of your resource card or the Centers for Medicare & Medicaid Services National Training Program website at cms.gov/outreach-and-education/training/cmsnationaltrainingprogram/index.html for a chart of the Parts A, B, C, and D appeals processes.

There is a standard process and an expedited [fast] process. It is important to note that for an expedited appeal, a provider must decide to terminate services or discharge you.

1. **Redetermination by the company that handles claims for Medicare within 120 days** from the date you get the "Medicare Summary Notice" (MSN). Details are on the MSN.
2. **Reconsideration by a Qualified Independent Contractor** (a contractor that didn't take part in the first decision). Details are included in the redetermination notice.
3. **Contact your Quality Improvement Organization** no later than noon the day before Medicare-covered services end to request a fast appeal.
4. **Hearing before an Administrative Law Judge (ALJ)** The amount of your claim must meet a minimum dollar amount, which is updated yearly: $140 in 2014. Send the request to the ALJ office listed in the reconsideration notice.
5. **Review by the Medicare Appeals Council (MAC).** Details on how to file are included in the ALJ's hearing decision. There's no minimum dollar amount to get your appeal reviewed by the MAC.
6. **Review by a federal district court.** To get a review by a federal court, the remaining amount in controversy of your case must meet a minimum dollar amount, which is updated yearly: $1,430 in 2014.

NOTE: See Appendix A for a full-size copy of the Original Medicare (Parts A and B) Appeals Process chart.



You may ask your doctor or health care provider for any information that may help your case if you decide to file a fast [expedited] appeal.

You must call your local Quality Improvement Organization (QIO) to request a fast appeal no later than noon on the day before your notice says your coverage will end.

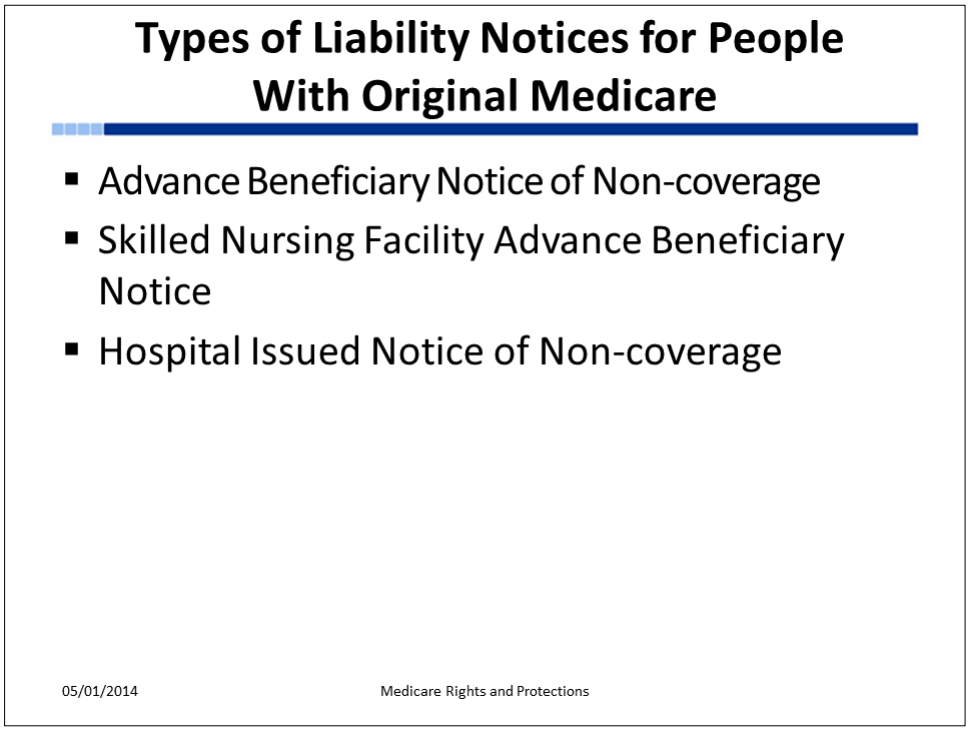
- The number for the QIO in your state should be on your notice. You can also call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you miss the deadline, you still have appeal rights:

- If you have Original Medicare, call your local QIO.
- If you are in a Medicare Advantage Plan, call your plan. Look in your plan materials to get the phone number.

Need more information?

Contact your local State Health Insurance Assistance Program (SHIP) if you need help filing an appeal. You can find SHIP contact information for your state at medicare.gov. Visit the "Medicare Helpful Contacts" page at medicare.gov/contacts/ and select your state or U.S. territory from the drop-down list.



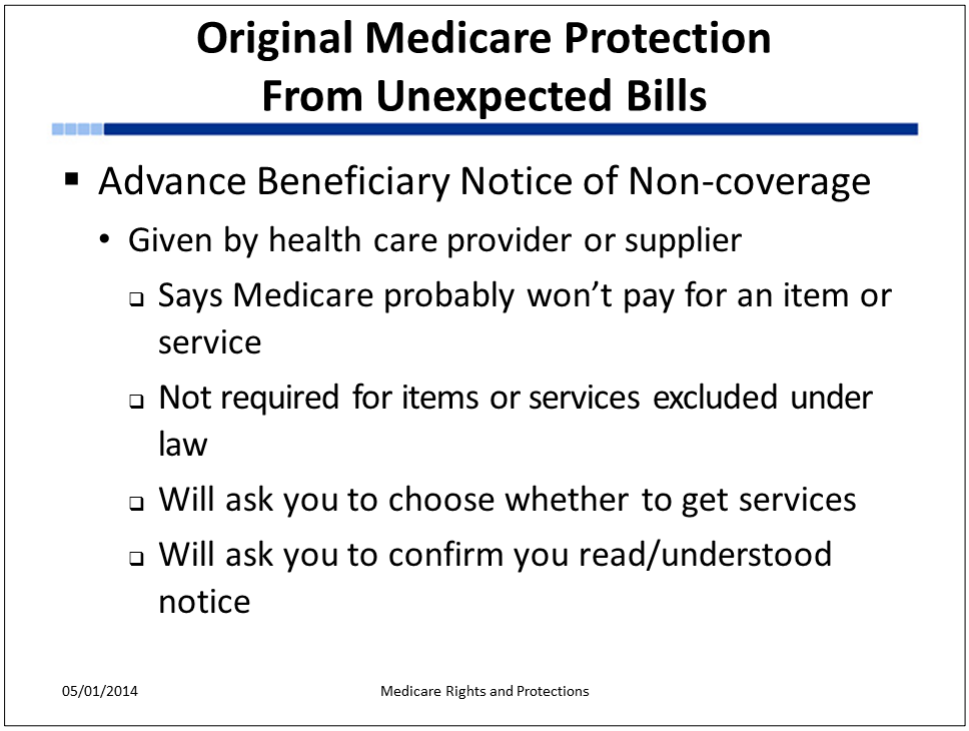
There are three primary types of liability notices for people with Original Medicare. These notices explain that you may be liable for the cost of certain services under certain conditions. The notices include

- **Advance Beneficiary Notice of Non-coverage (ABN) –** Used by providers and suppliers of Medicare Part B (Medical Insurance) items and services. It is also used by hospices and religious nonmedical health care institutes providing Medicare Part A (Hospital Insurance) items and services.

There are other types of liability notices for people with Original Medicare that are used in specific health care settings. Like ABN, these notices explain that you may be liable for the cost of certain services under certain conditions. These notices include

- **Skilled Nursing Facility Advance Beneficiary Notice -** only used for skilled nursing facility care
- **Hospital Issued Notice of Non-coverage** - used for inpatient hospital care when the hospital thinks Medicare may not pay for some or all of your care

You can view or print these notices at cms.gov/bni/.



You are protected from unexpected bills. If your health care provider or supplier believes that Medicare won't pay for certain items or services, in many situations they will give you a notice that says Medicare probably won't pay for an item or service under Original Medicare. This is called an Advance Beneficiary Notice of Non-coverage (ABN). ABN is used by providers and suppliers of Medicare Part B (Medical Insurance) items and services. It is also used by hospice and religious nonmedical health care institutes providing Medicare Part A (Hospital Insurance) items and services.

You will be asked to choose an option on the ABN form and sign it to say that you have read and understand the notice. If you choose to get the items or services listed on ABN, you will have to pay if Medicare doesn't. In some cases, the provider may ask for payment at the time the service is received.

Providers (including independent laboratories), physicians, practitioners, and suppliers will use ABN (Form CMS-R-131) for situations where Medicare payment is expected to be denied because the item or service may not be reasonable and necessary.

Doctors and suppliers aren't required to give you an ABN for services Medicare never covers (i.e., excluded under Medicare law), such as routine eye exams, dental services, hearing aids, and routine foot care; however, they may voluntarily give you an ABN for items and services excluded by Medicare as a courtesy.

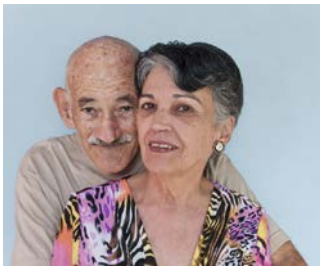
Need more information?

See Appendix D for a copy of ABN. It's also available at cms.gov/medicare/medicare-general-information/bni/abn.html.

Check Your Knowledge—Question 3

The Advance Beneficiary Notice of Non-coverage is required to be used by all providers for all non-covered Original Medicare services.

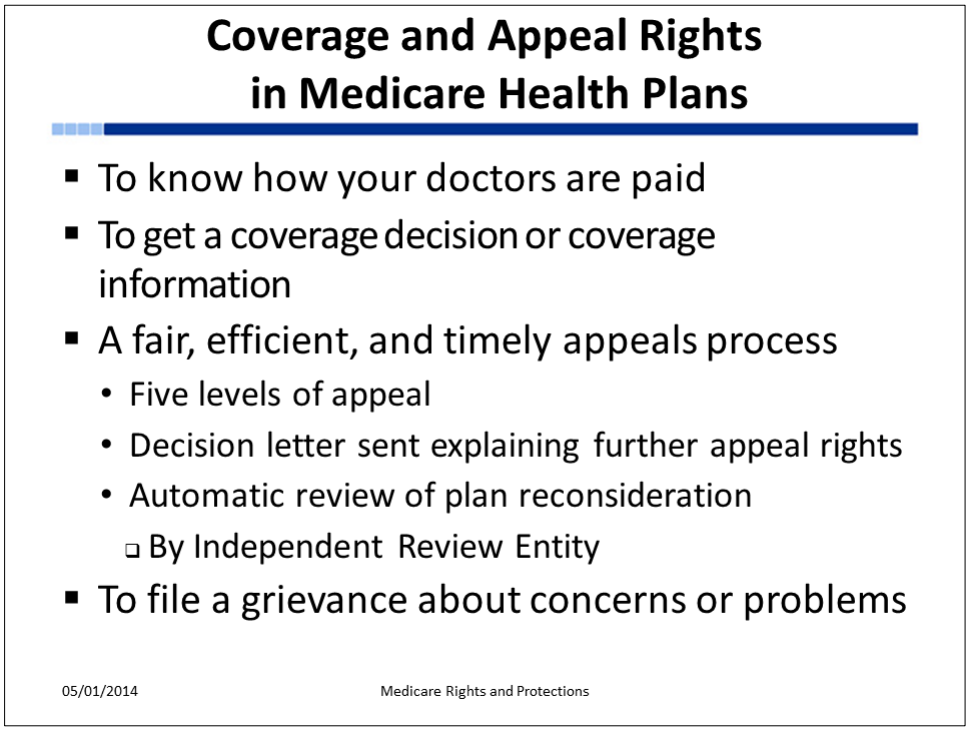
a. True
b. False



Refer to page 67 to check your answers.

If you're in a Medicare health plan, in addition to the rights and protections previously listed in the first section, you have the following rights:

- To choose health care providers within the plan, so you can get health care you need.
- To get a treatment plan from your doctor if you have a complex or serious medical condition. A treatment plan lets you directly see a specialist within the plan as many times as you and your doctor think you need. Women have the right to go directly to a women's health care specialist without a referral within the plan for routine and preventive health care services.

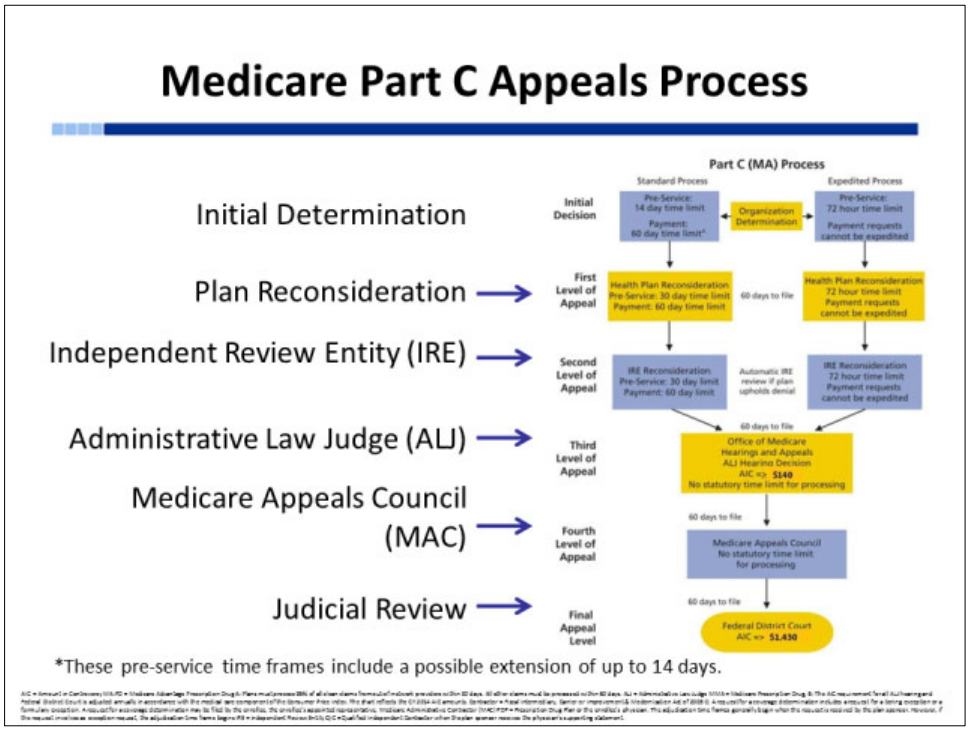


If you're in a Medicare health plan, you have the following rights:

- To know how your doctors are paid. Medicare doesn't allow a plan to pay doctors in a way that interferes with you getting needed care.
- To find out from your plan, before you get a service or supply, if it'll be covered. You can call your plan to get information about your coverage rules.
- A fair, efficient, and timely appeals process to resolve differences with your plan. You have the right to ask your plan to provide or pay for an item or service you think should be covered, provided, or continued.
    - The appeals process consists of five levels.
    - If coverage is denied at any appeal level, the enrollee will receive a letter explaining the decision and instructions on how to proceed to the next appeal level.
    - If the plan continues to deny coverage at the reconsideration level, the appeal is automatically sent to the Part C (Medicare Advantage) Independent Review Entity.
    - To file a grievance about other concerns or problems with your plan, check your plan's membership materials, or call your plan to find out how to file a grievance.

Need more information?

See "Medicare Rights & Protections" (CMS Product No. 11534) for more details: medicare.gov/Publications/Pubs/pdf/11534.pdf.



This chart shows the appeals process for Medicare Advantage Plan or other Medicare health plan enrollees. The time frames differ depending on whether you're requesting a standard appeal, or if you qualify for an expedited [fast] appeal.

If you ask your plan to provide or pay for an item or service and your request is denied, you can appeal the plan's initial decision (the "organization determination"). You'll get a notice explaining why your plan denied your request and instructions on how to appeal your plan's decision.

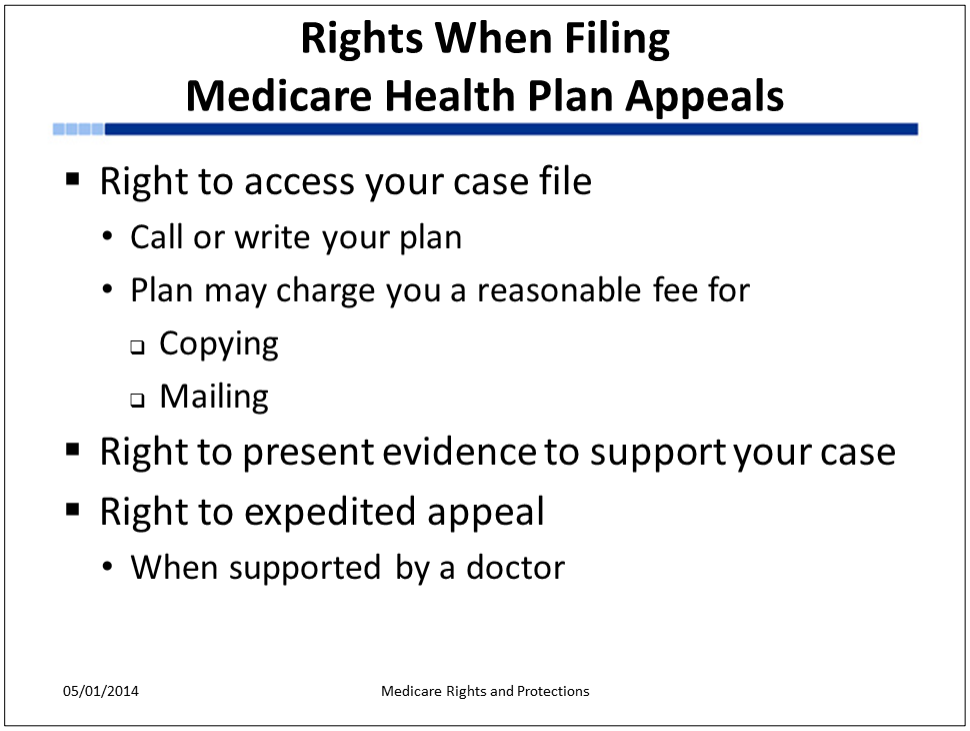
There are five levels of appeal. If you disagree with the decision made at any level of the process, you can go to the next level if you meet the requirements for doing so.

After each level, you'll get instructions on how to proceed to the next level of appeal. The five levels of appeal are

- Reconsideration by the plan
- Reconsideration by the Independent Review Entity
- Hearing with the Administrative Law Judge
- Review by the Medicare Appeals Council
- Review by a federal district court

Need more information?

See Appendix B for a full-size copy of the Part C (Medicare Advantage) Appeals Process chart.



If you're in a Medicare Advantage or other Medicare health plan and you're filing an appeal, you have certain rights. You may want to call or write your plan and ask for a copy of your case file. To get the phone number or address of your plan, look at your "Evidence of Coverage," or the notice you received that explained why you could not get the services you requested.

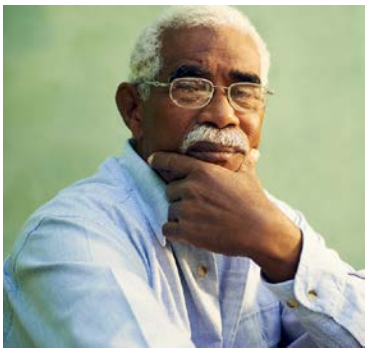
The plan may charge you a fee for copying this information and sending it to you. Your plan should be able to give you an estimate of how much it'll cost based on the number of pages in the file, plus normal mail delivery.

You also have the right to an expedited appeal when your request is supported by a doctor, or when applying the standard appeal time frame could seriously jeopardize your life or health, or your ability to regain maximum function.

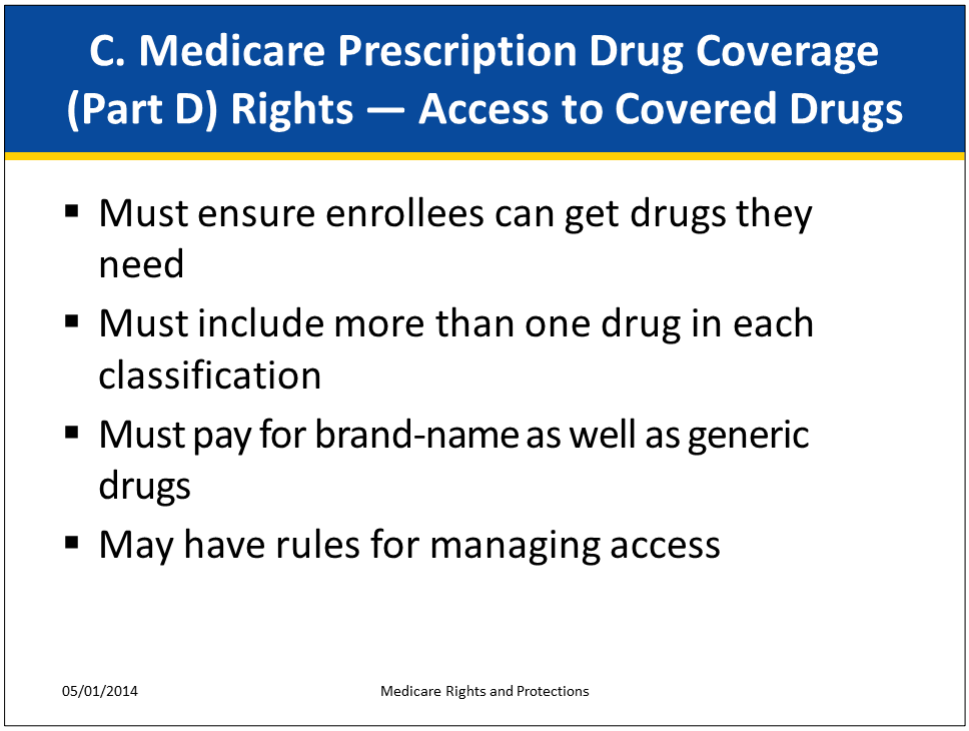
Check Your Knowledge—Question 4

If you join a Medicare Advantage Plan, you have fewer rights than in Original Medicare when making an appeal.

a. True
b. False



Refer to page 68 to check your answers.

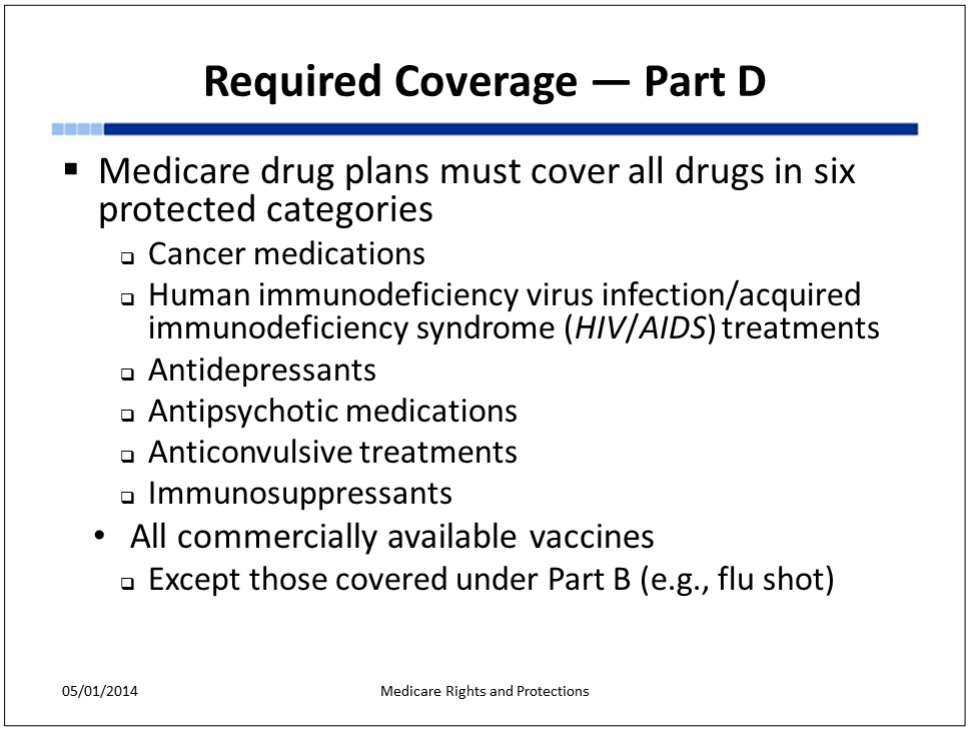


Medicare drug plans work to provide people with Medicare high-quality, cost-effective drug coverage. Medicare drug plans must ensure that their enrollees can get medically-necessary drugs to treat their conditions.

Each plan has a list of covered drugs called a formulary. A plan's formulary may not include every drug you take. However, in most cases, a similar drug that is safe and effective will be available.

Plans must pay for both brand-name and generic drugs. Covered drugs include prescription drugs, biological products, and insulin. Medical supplies associated with the injection of insulin, such as syringes, needles, alcohol swabs, and gauze are also covered.

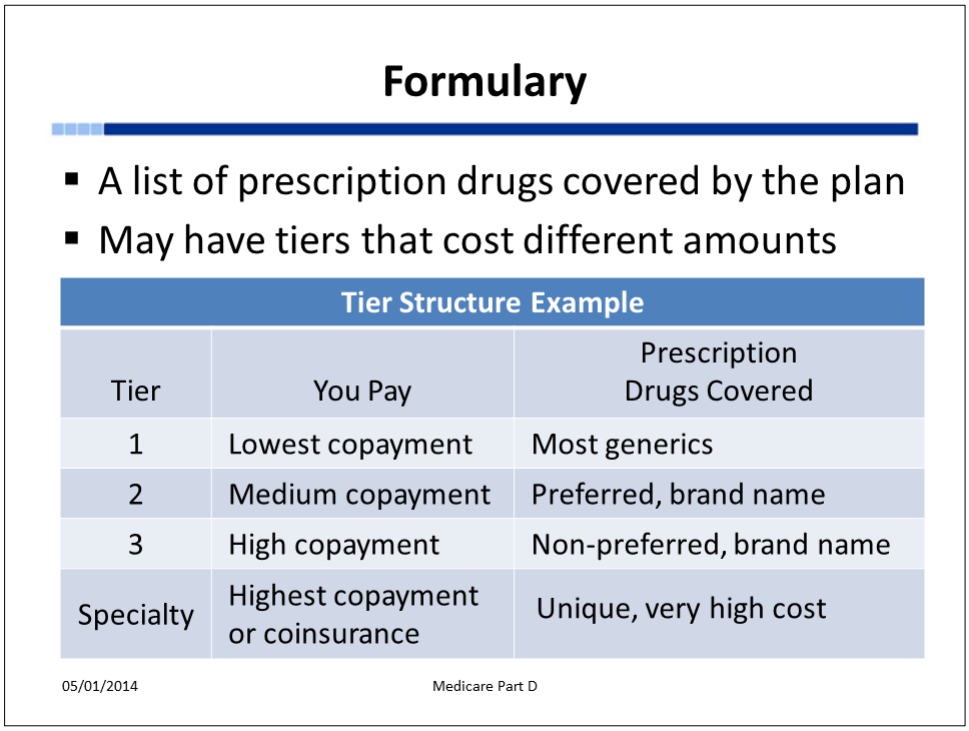
Some of the methods that plans use to manage access to certain drugs include prior authorization, step therapy, and quantity limits, which we'll discuss in this section.



Medicare drug plans must cover all drugs in six categories to treat certain conditions:

- Cancer medications
- Human immunodeficiency virus infection/acquired immunodeficiency syndrome (HIV/AIDS) treatments
- Antidepressants
- Antipsychotic medications
- Anticonvulsive treatments for epilepsy and other conditions
- Immunosuppressants

Also, Medicare drug plans must cover all commercially available vaccines, including the shingles vaccine, but not vaccines covered under Part B (Medical Insurance), such as the flu and pneumococcal pneumonia shots. You or your provider can contact your Medicare drug plan for more information about vaccine coverage.

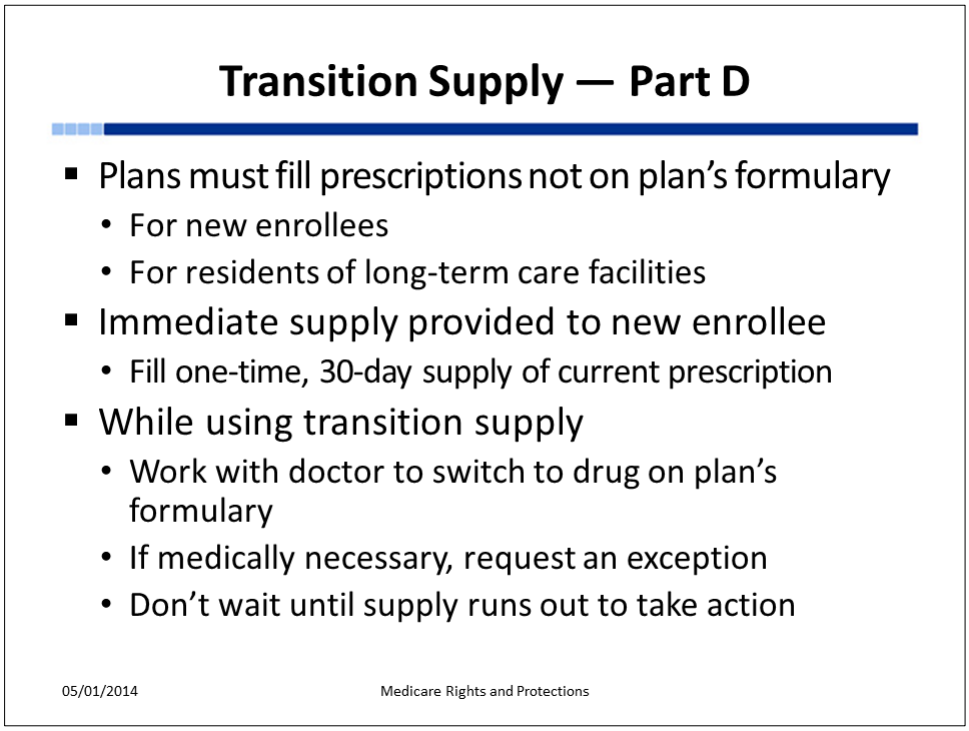


Each Medicare drug plan has a list of prescription drugs that it covers called a formulary. Each formulary must include a range of drugs in the prescribed categories and classes. To offer lower costs, many plans place drugs into different tiers, which cost different amounts. Each plan can form its tiers in different ways.

Here's an example of how a plan might form its tiers:

- **Tier 1 – Generic drugs** (the least expensive) – A generic drug is the same as its brand-name counterpart in safety, strength, quality, the way it works, how it's taken, and the way it should be used. Generic drugs use the same active ingredients as brand-name drugs. Generic drug makers must prove that their product performs the same way as the corresponding brand-name drug; they're also less expensive because of market competition. Generic drugs are thoroughly tested and must be approved by the U.S. Food and Drug Administration. Today, almost half of all prescriptions in the United States are filled with generic drugs. In some cases, there may not be a generic drug available for the brand-name drug you take. Talk to your prescriber.
- **Tier 2 – Preferred brand-name drugs** - Tier 2 drugs cost more than Tier 1 drugs.
- **Tier 3 – Non-preferred brand-name drugs** - Tier 3 drugs cost more than Tier 2 drugs.
- **Specialty Tier** – These drugs are unique and have a high cost.

NOTE: In some cases, if your drug is in a higher (more expensive) tier and your prescriber thinks you need that drug instead of a similar drug on a lower tier, you can request an exception and ask your plan for a lower copayment.



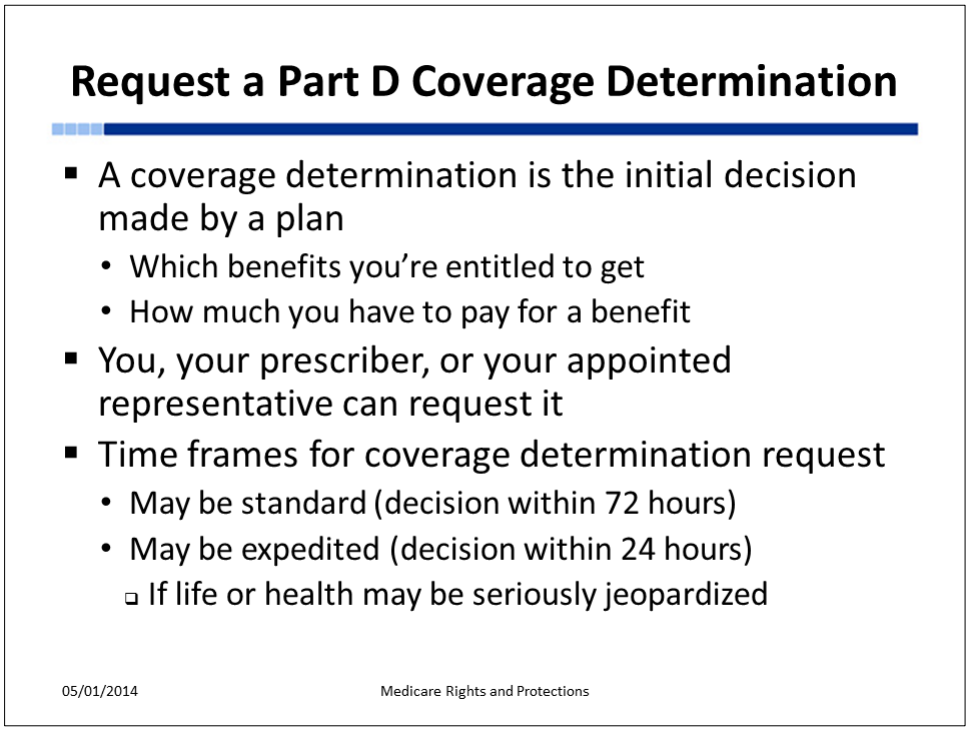
Some new plan members may already be taking a drug that's not on their plan's drug list or that is a step-therapy drug. Medicare requires the plans to provide a standard 30-day transition supply of all Medicare-covered drugs, even if the prescription is for a drug that's not on the plan's drug list, is a step-therapy drug, or requires prior authorization. This gives you and your doctor time to find another drug on the plan's drug list that would work as well. However, if you have already tried similar drugs and they didn't work, or if the doctor believes that because of your medical condition you must take a certain drug, the doctor can contact the plan to request an exception to the formulary rules. If the doctor's request is approved, the plan will cover the drug. If the exception is not granted, you can file an appeal.

It's important to understand how to work with your plan's formulary and to plan ahead. If you receive a transition supply, you shouldn't wait until that supply is gone to take action. You should talk to your doctor about

- Prior authorization (if necessary)
- Safe and effective alternative drugs that may also save you money
- Requesting an exception, if necessary for your condition

You should contact your drug plan with any questions about what's covered by the plan.

NOTE: In most cases with step therapy drugs, the plan member must try certain less-expensive drugs first.



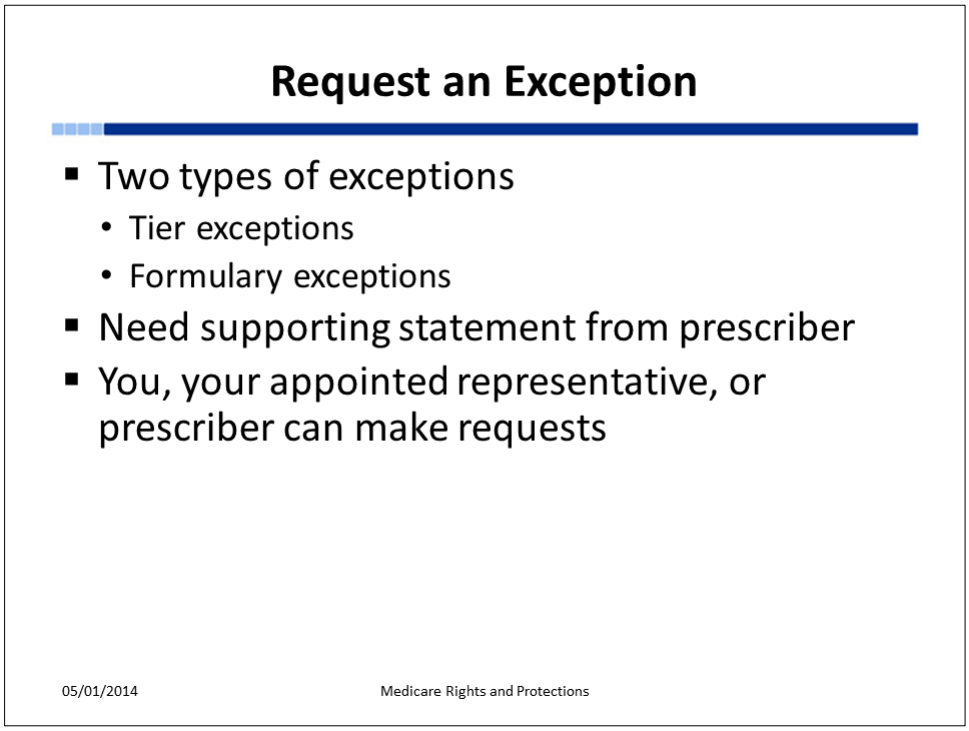
A coverage determination is the first decision made by your Medicare drug plan (not the pharmacy) about your prescription drug benefits. This includes whether a certain drug is covered, whether you have met all the requirements for getting a requested drug, and how much you must pay for a drug.

You, your prescriber, or your appointed representative can ask for a coverage determination by calling your plan or writing them a letter. If you write to the plan, you can write a letter or use the "Model Coverage Determination Request" form found at: cms.gov/medicare/appeals-and-grievances/medprescriptdrugapplgriev/forms.html.

There are two types of coverage determinations: standard or expedited. Your request will be sped up [expedited] if the plan determines, or if your doctor tells the plan that your life or health may be seriously jeopardized by waiting for a standard request.

A plan must give you its coverage determination decision as quickly as your health condition requires. After getting your request, the plan must give you its decision no later than 72 hours for a standard determination, or 24 hours for an expedited determination. If your coverage determination request involves an exception, the time clock starts when the plan gets your doctor's supporting statement.

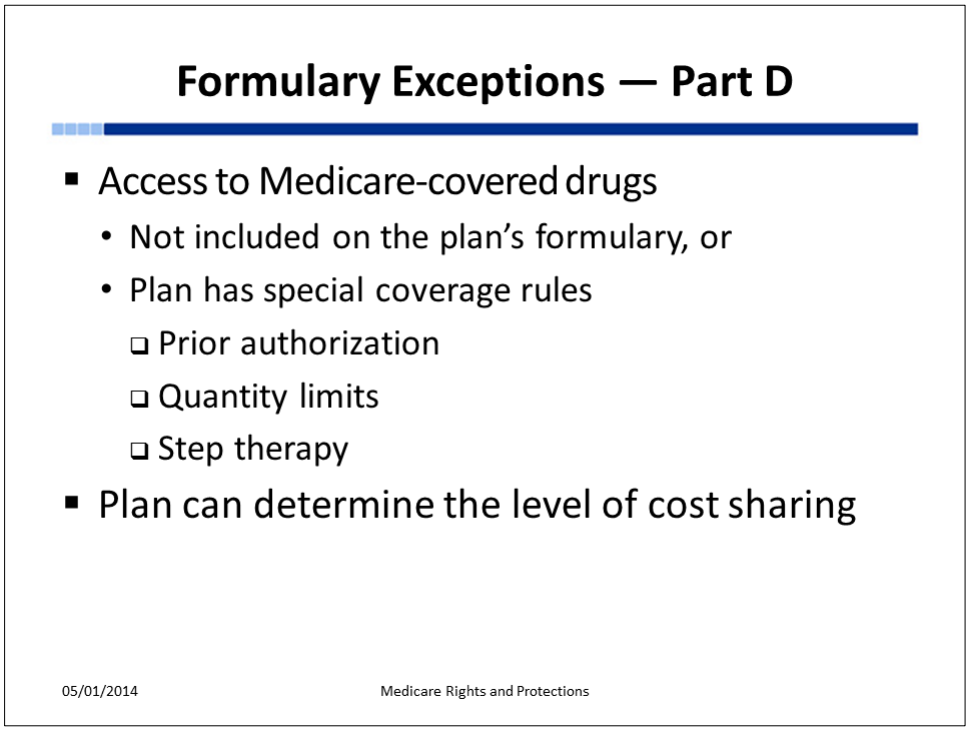
If a plan fails to meet these time frames, it must automatically forward the request and case file to the Independent Review Entity (IRE) for review, and the request will skip over the first level of appeal (redetermination by the plan). The IRE is MAXIMUS. You can find its contact information at medicarepartdappeals.com.



An exception is a type of coverage determination. There are two types of exceptions: tier exceptions (such as getting a Tier 3 drug at the Tier 2 cost) and formulary exceptions (either coverage for a drug not on the plan's formulary, or relaxed access requirements).

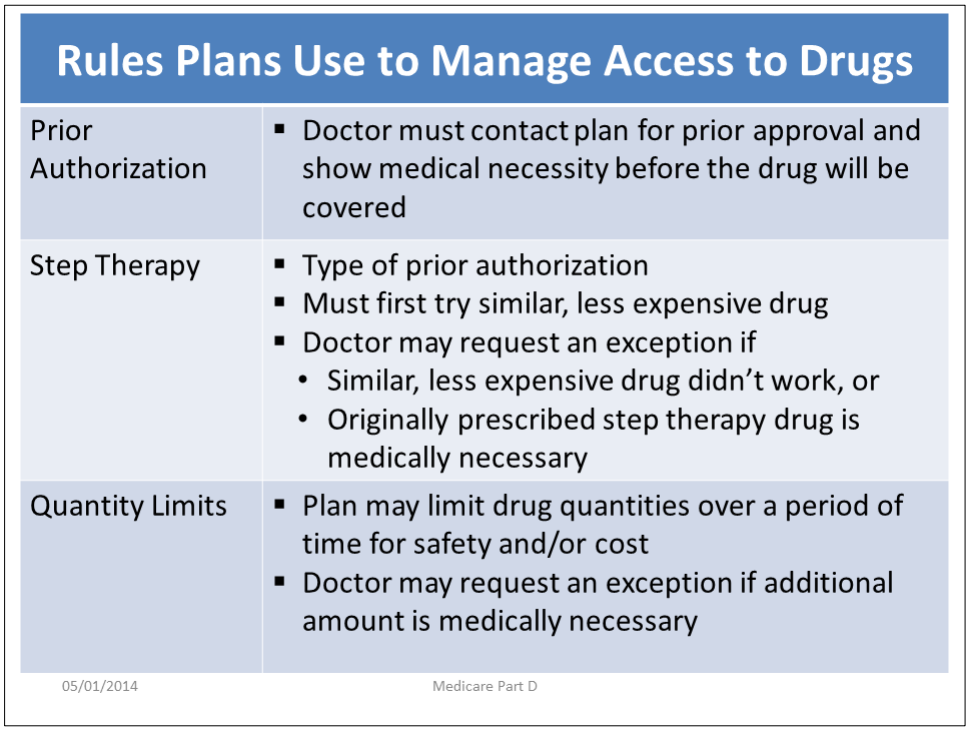
If you want to make an exception request, you'll need a supporting statement from the prescriber. In general, the statement must point out the medical reason for the exception. The prescriber may give the statement verbally or in writing.

NOTE: If you choose to have a representative help you with a coverage determination or appeal, you and the person you want to help you must fill out the Appointment of Representative form (Form CMS-1696). You can get a copy of the form at cms.gov/cmsforms/downloads/cms1696.pdf. You can also appoint a representative with a letter signed and dated by you and the person helping you, but the letter must have the same information that's requested on the Appointment of Representative form. You must send the form or letter with your coverage determination or appeal request.



Formulary exceptions ensure enrollees have access to Medicare-covered drugs that are not included on the plan's formulary or for which the plan has special coverage rules. These special rules include prior authorization, quantity limits, and step therapy.

When a formulary exception is approved, the plan has the flexibility to determine the level of cost sharing that will apply for the non-formulary drug(s). For example, a plan sponsor may apply the non-preferred level of cost sharing for all non-formulary drugs approved under the exception process.



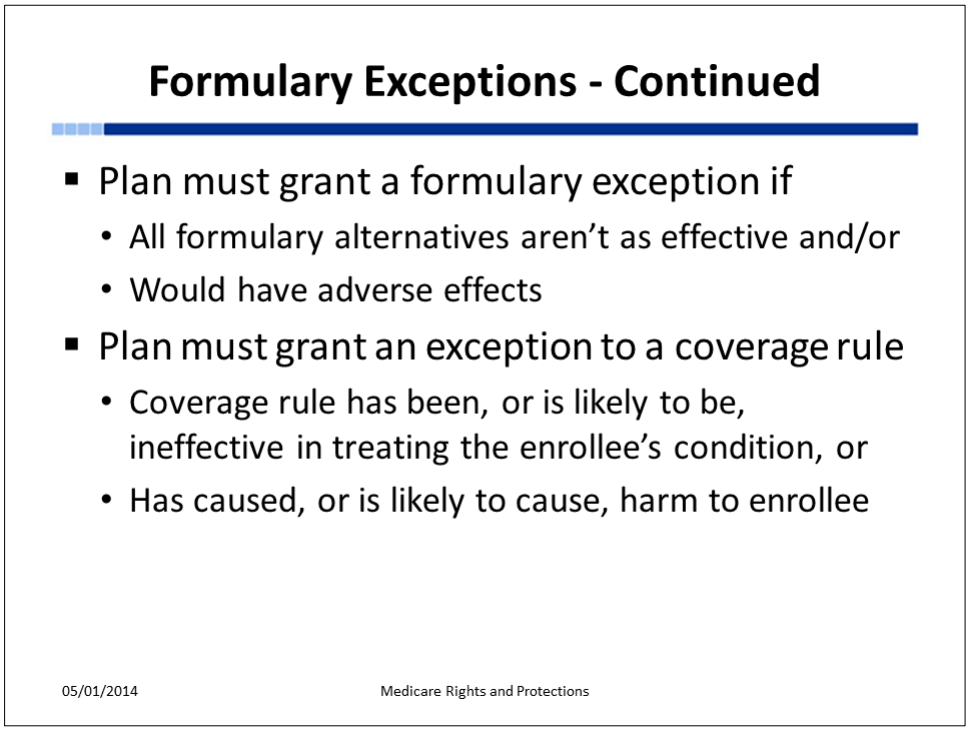
Medicare drug plans manage access to covered drugs in several ways, including prior authorization, step therapy, and quantity limits.

You may need drugs that require prior authorization. This means before the plan will cover a particular drug, your doctor or other prescriber must first show the plan you have a medically-necessary need for that particular drug. Plans also do this to be sure you're using these drugs correctly. Contact your plan about its prior authorization requirements, and talk with your prescriber.

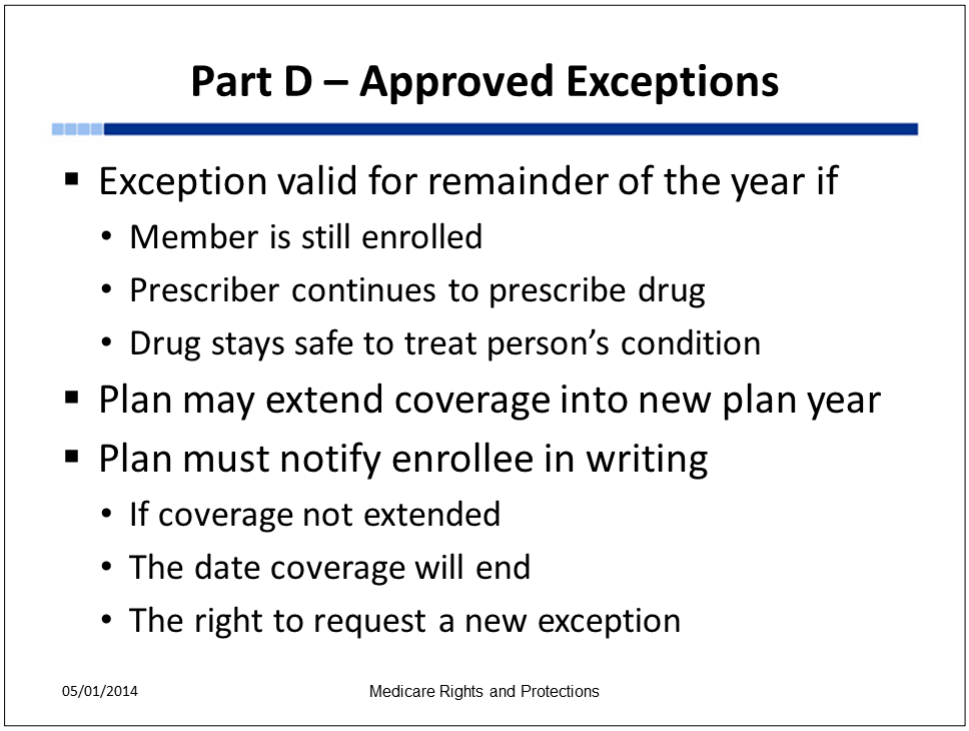
Step therapy is a type of prior authorization. In most cases, you must first try a certain less-expensive drug on the plan's drug list that has been proven effective for most people with your condition before you can move up a step to a more expensive drug. For instance, some plans may require that you first try a generic drug (if available), then a less expensive brand-name drug on their drug list before you can get coverage for a similar, more expensive brand-name drug.

However, if you've already tried a similar, less expensive drug that didn't work, or if the doctor believes that because of your medical condition it's medically necessary to take a step therapy drug (the drug the doctor originally prescribed), you (with your doctor's help) can contact the plan to request an exception. If the request is approved, the plan will cover the originally prescribed step therapy drug.

For safety and cost reasons, plans may limit the quantity of drugs they cover over a certain period of time. If your prescriber believes that, because of your medical condition, a quantity limit isn't medically appropriate, you or your prescriber can contact the plan to ask for an exception. If the plan approves your request, the quantity limit won't apply to your prescription.



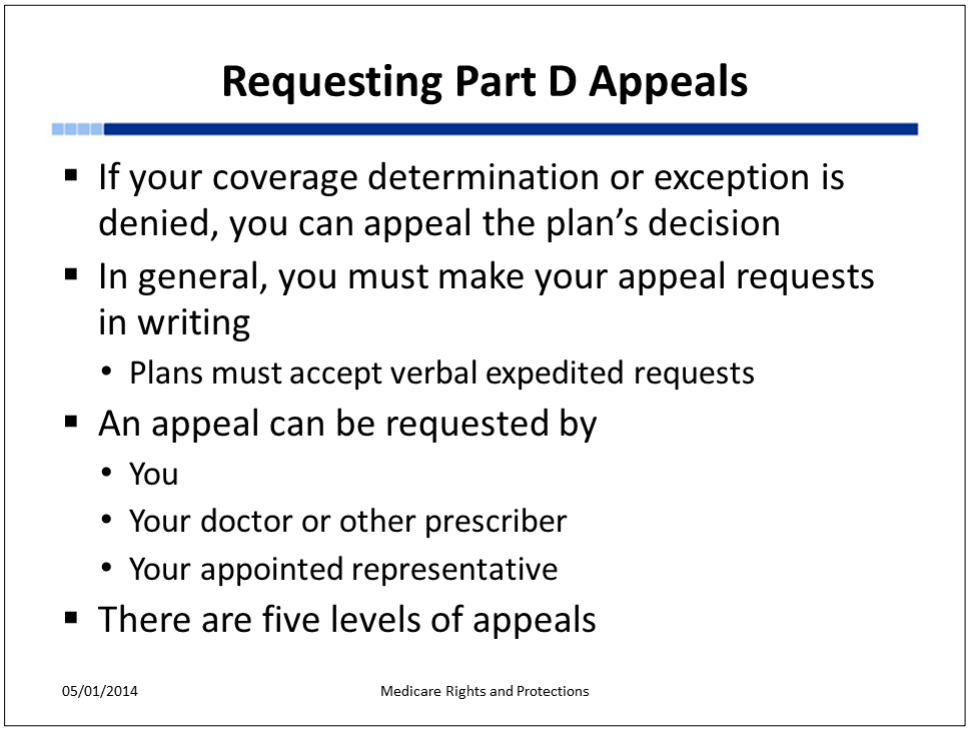
A plan must grant a formulary exception when it determines that none of the formulary alternatives for treatment of the same condition would be as effective for the enrollee as the non-formulary drug and/or would have an adverse effect. A plan must grant an exception to a coverage rule when it determines the coverage rule has been, or is likely to be, ineffective in treating the enrollee's condition, or has caused, or is likely to cause, harm to the enrollee.



If an exception request is approved, the exception is valid for refills for the remainder of the plan year, as long as

- The member remains enrolled in the plan
- The physician continues to prescribe the drug
- The drug remains safe for treating the person's condition

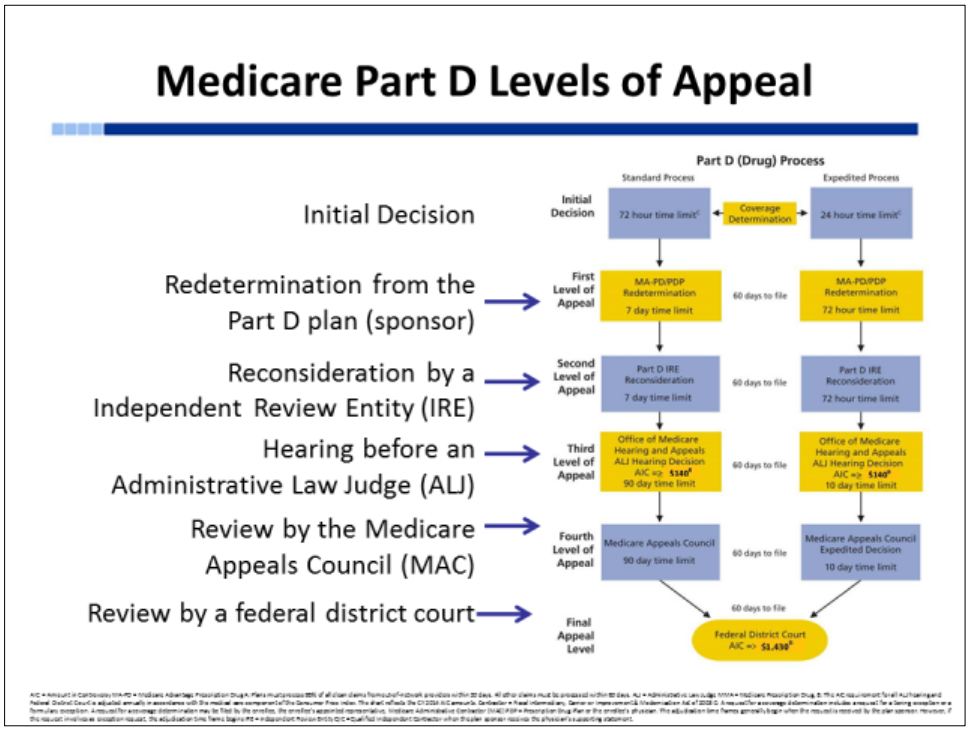
A plan may choose to extend coverage into a new plan year. If it doesn't, it must provide written notice to the member either at the time the exception is approved, or at least 60 days before the plan year ends. The written notice must tell the member about the date coverage will end, the right to request a new exception, and the process for making a new exception request. If coverage isn't extended, the member should consider switching to a drug on the plan's formulary, requesting another exception, or changing plans during the Medicare Open Enrollment Period also known as Open Enrollment.



If you disagree with your Medicare drug plan's coverage determination or exception decision, you have the right to appeal the decision. Your plan's written decision will explain how you may file an appeal. Read this decision carefully and call your plan if you have questions.

In general, you must make your appeal requests in writing. However, plans must accept verbal expedited redetermination requests. In addition, plans may choose to accept verbal standard redetermination requests. Check your plan materials, or contact your plan to see if you can make verbal standard redetermination requests.

You, or your appointed representative, may ask for any level of appeal. However, your doctor or other prescriber can ask for a redetermination or Independent Review Entity reconsideration (level one or two appeal), or an expedited redetermination on your behalf and doesn't have to be your appointed representative.



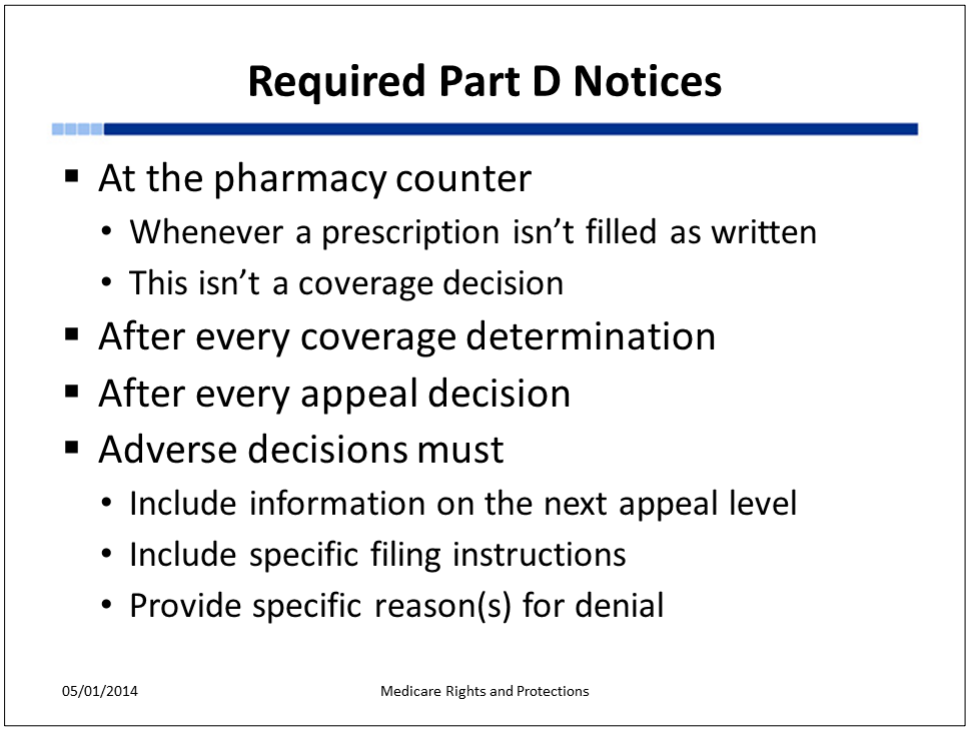
If you receive an unfavorable initial decision, you have the right to appeal the decision.

There are five levels of appeal:

1. Redetermination from the Part D plan (sponsor)
2. Reconsideration by an Independent Review Entity
3. Hearing before an Administrative Law Judge
4. Review by the Medicare Appeals Council
5. Review by a federal district court

Need more information?

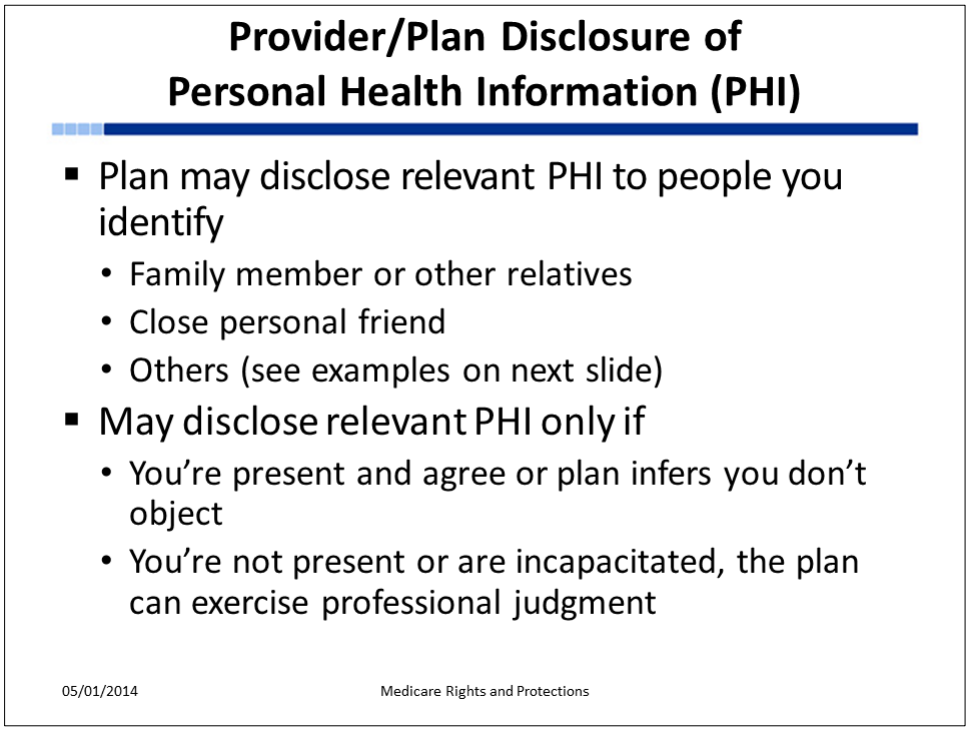
See Appendix C for a full-size copy of the Part D (Drug) Appeals Process chart.



Plan sponsors must ensure that their network pharmacies provide a Pharmacy Notice whenever a prescription can't be filled as written.

Plans' sponsors are required to provide written notices after every coverage determination or appeal decision.

In addition, all other appeal entities are required to send written notice of decisions. If a decision is adverse, the notice will explain the decision, include information on the next appeal level, and provide specific instructions about how to file an appeal.



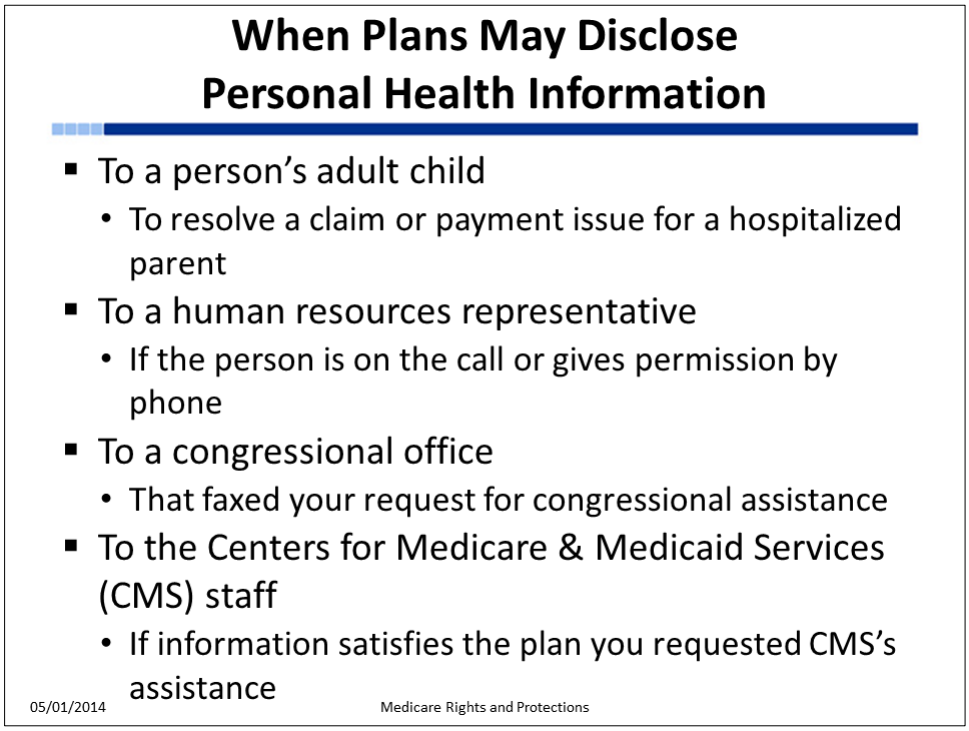
A health care provider or plan, such as a Medicare drug plan, may disclose relevant protected Personal Health Information (PHI) to someone who assists you, specifically regarding your drug coverage. However, the guidance applies to all providers and plans, not just drug plans. It's important to note that health plans are permitted, but not required, to make these disclosures.

Your plan may disclose relevant PHI to those identified by you as being involved in your care or payment, including the following:

- Family members or other relatives
- Close personal friends
- Others (see examples on the next slide)

Your plan may disclose relevant PHI to those identified by you only under the following conditions:

- When you're present and agree or the plan reasonably infers from the circumstances that you don't object
- When you're not present or are incapacitated, the plan may exercise its professional judgment to determine whether disclosure is in your best interest



A plan may disclose Personal Health Information (PHI) to

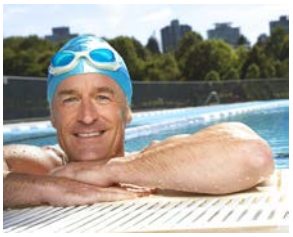
- A person's adult child who is resolving a claim or payment issue for a hospitalized parent
- A human resources representative if the person with Medicare is on the line or gives permission by phone
- A congressional office or staff person that has faxed the person's request for congressional assistance
- The Centers for Medicare & Medicaid Services' (CMS's) staff if the available information satisfies the plan that the individual requested CMS's assistance

NOTE: PHI guidelines were published by the Office for Civil Rights, U.S. Department of Health and Human Services.

Check Your Knowledge—Question 5

A drug plan must respond to a standard coverage determination request for medication within

a. 48 hours
b. 72 hours
c. 60 hours



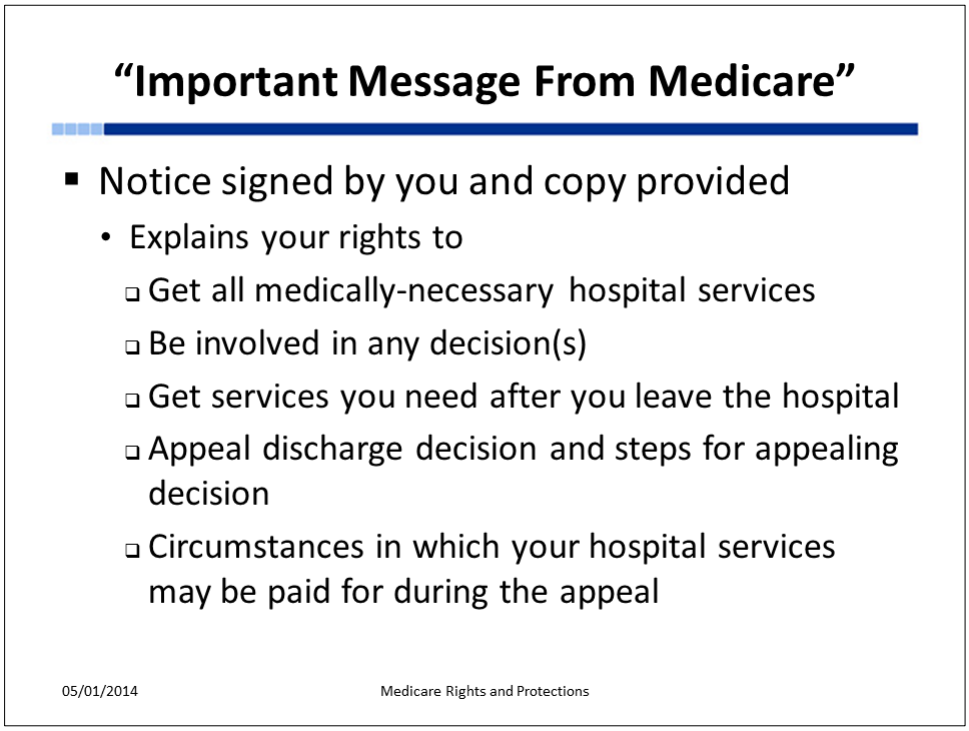
Refer to page 68 to check your answers.

Lesson 2, "Your Rights in Certain Settings," explains your guaranteed rights when you're admitted to a hospital or skilled nursing facility, or you're receiving care from a non-institutional provider, such as home health, hospice, or a Comprehensive Outpatient Rehabilitation Facility.

Many of these rights and protections are the same whether you're in Original Medicare, a Medicare Advantage Plan (like a Health Maintenance Organization or Preferred Provider Organization), or other Medicare health plan.

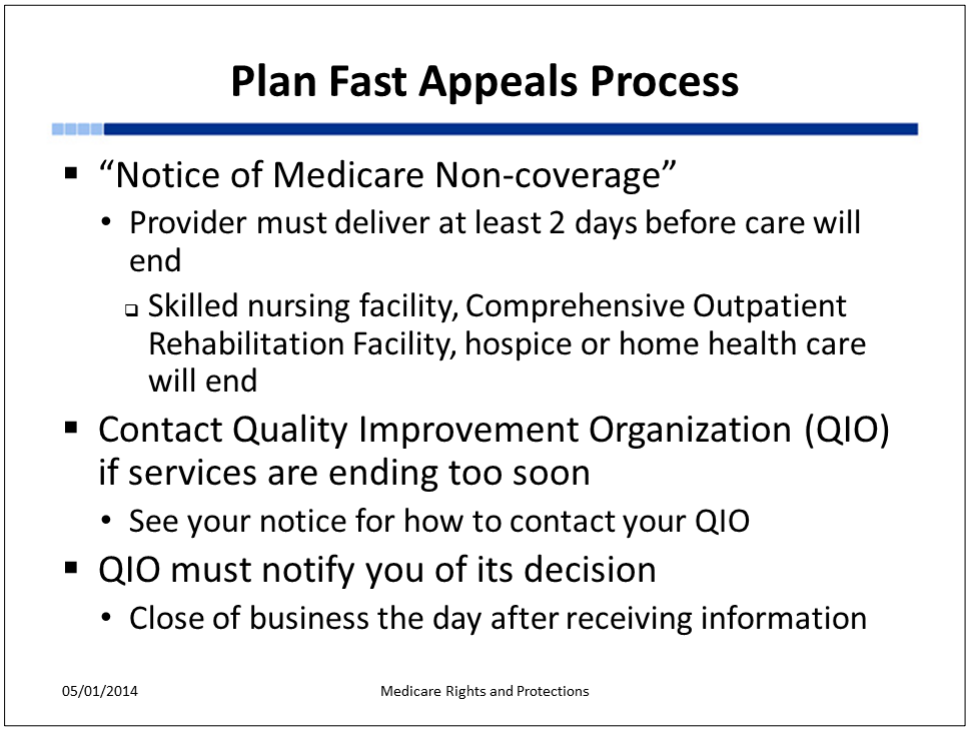
All people with Medicare, including those in Medicare Advantage or other Medicare health plans, have the right to get all of the Medicare-covered hospital care they need to diagnose and treat their illness or injury, including any follow-up care they need after leaving the hospital.

When admitted to the hospital as an inpatient, you'll receive a notice called an "Important Message From Medicare About Your Rights," and the hospital must provide you with a copy of the notice so that you know your rights as a hospital inpatient.



The "Important Message From Medicare" is a notice you receive after being admitted to the hospital. This notice is signed by you, and a copy is provided to you explaining your rights:

- Get all medically-necessary hospital services
- Be involved in any decision(s)
- Get services you need after you leave the hospital
- Appeal discharge decision and steps for appealing decision
- Circumstances in which your hospital services may be paid for during the appeal



With the Medicare Health Plan Fast Appeals Process

- You have the right to ask the Quality Improvement Organization (QIO) to require your plan to provide or pay for a Medicare-covered service you think should be continued in a skilled nursing facility, from a home health agency, hospice, or in a Comprehensive Outpatient Rehabilitation Facility.
- Your provider must deliver a "Detailed Notice of Medicare Non-coverage" at least 2 days before Medicare-covered hospice, skilled nursing facility, Comprehensive Outpatient Rehabilitation Facility, or home health care will end.
- If you think services are ending too soon, contact your QIO no later than noon the day before Medicare-covered services end to request a fast appeal.

See your notice for how to contact your QIO and for other important information.

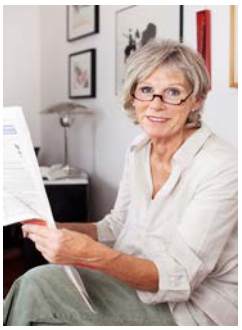
The QIO must notify you of its decision by close of business of the day after it receives all necessary information.

The plan must give you a "Detailed Explanation of Non-coverage." This notice will explain why the coverage is being discontinued.

You have the right to ask for a reconsideration by the Qualified Independent Contractor (QIC) if you are dissatisfied with the results of the fast appeal. The QIC is an independent contractor who didn't take part in the first fast appeal decision. The decision notice that you receive from your first fast appeal will have directions on how to file a request for reconsideration.

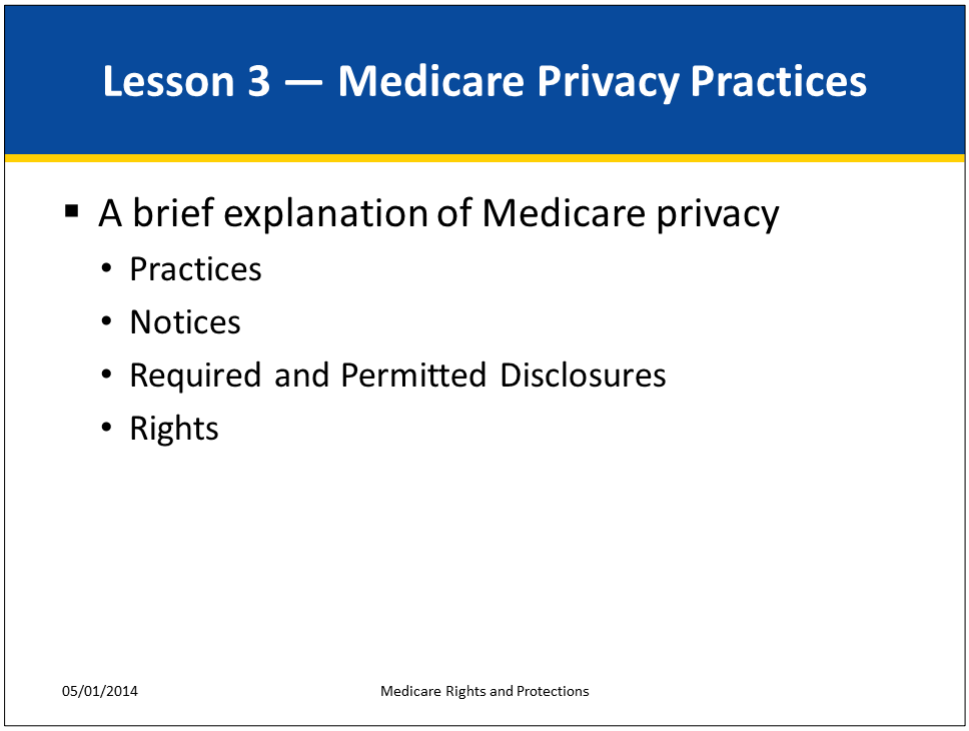
Check Your Knowledge—Question 6

The "Important Message From Medicare" is an optional notice provided to a person with Medicare who is admitted to the hospital at the hospital's discretion.

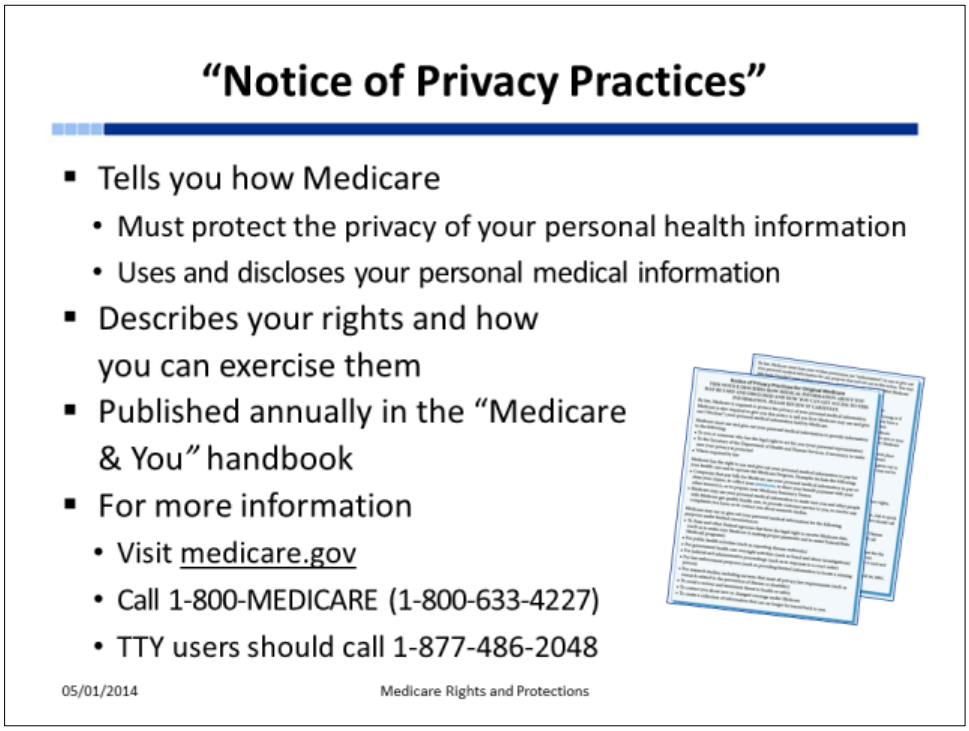


a. True
b. False

Refer to page 68 to check your answers.



Lesson 3, "Medicare Privacy Practices," explains Medicare's privacy practices, notices, required and permitted disclosures, and rights.

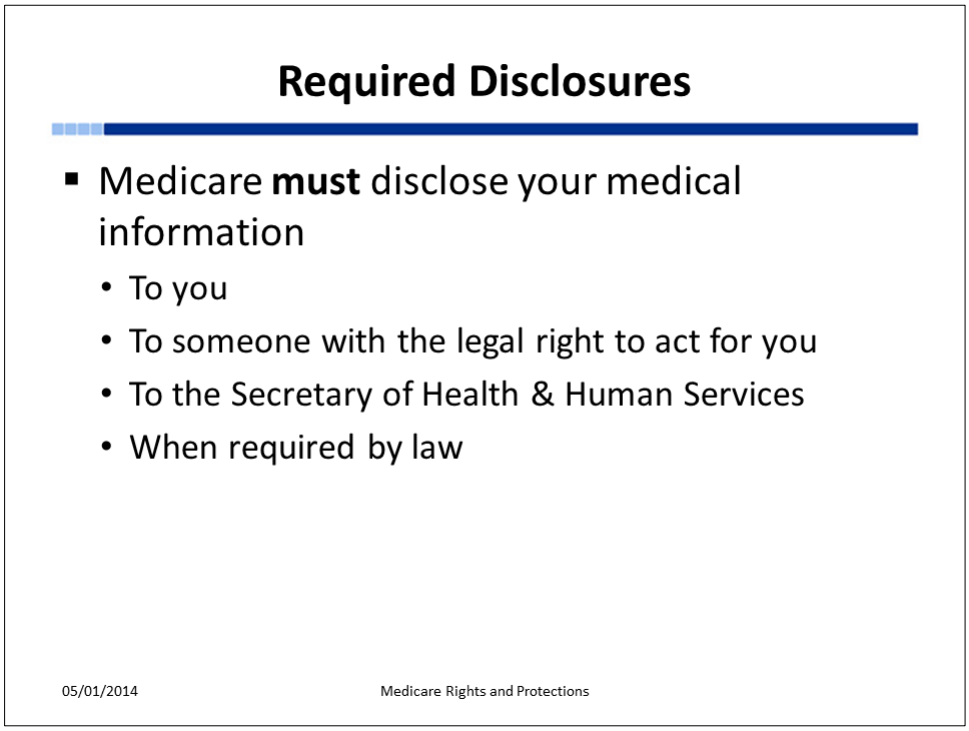


Medicare is required to protect your personal medical information. The "Notice of Privacy Practices for Original Medicare" describes how Medicare uses and gives out your personal health information and tells you your individual rights. If you're enrolled in a Medicare Advantage Plan or other Medicare health plan, or in a Medicare Prescription Drug Plan, your plan materials describe your privacy rights.

- The "Notice of Privacy Practices" is published annually in the "Medicare & You" handbook.

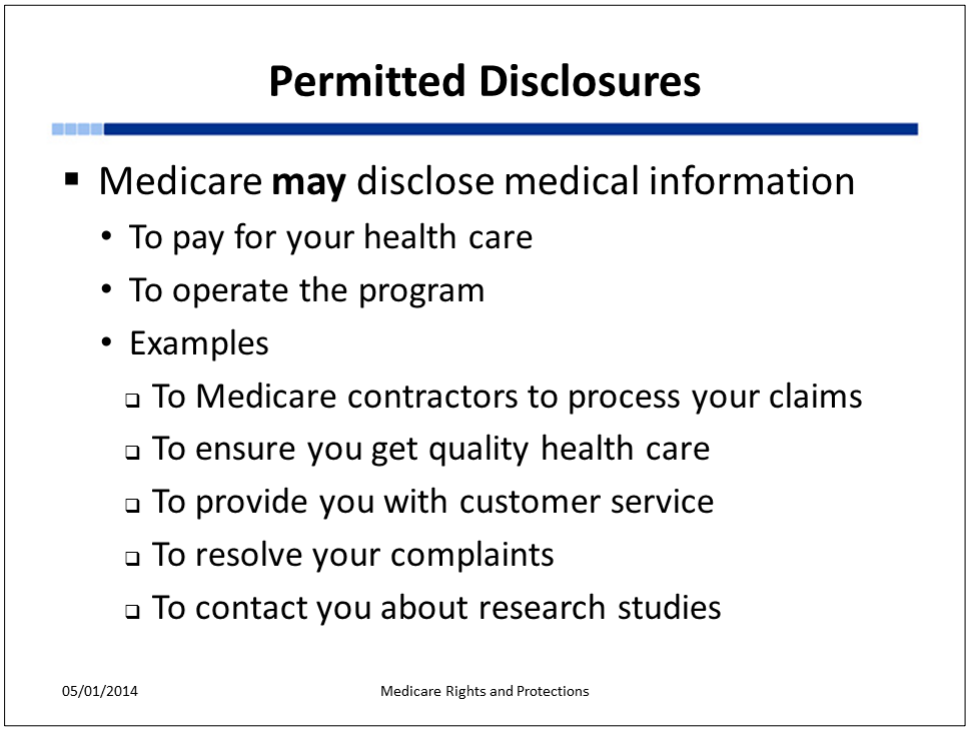
Need more information?

For more information, go to medicare.gov or call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.



Medicare must disclose your personal medical information

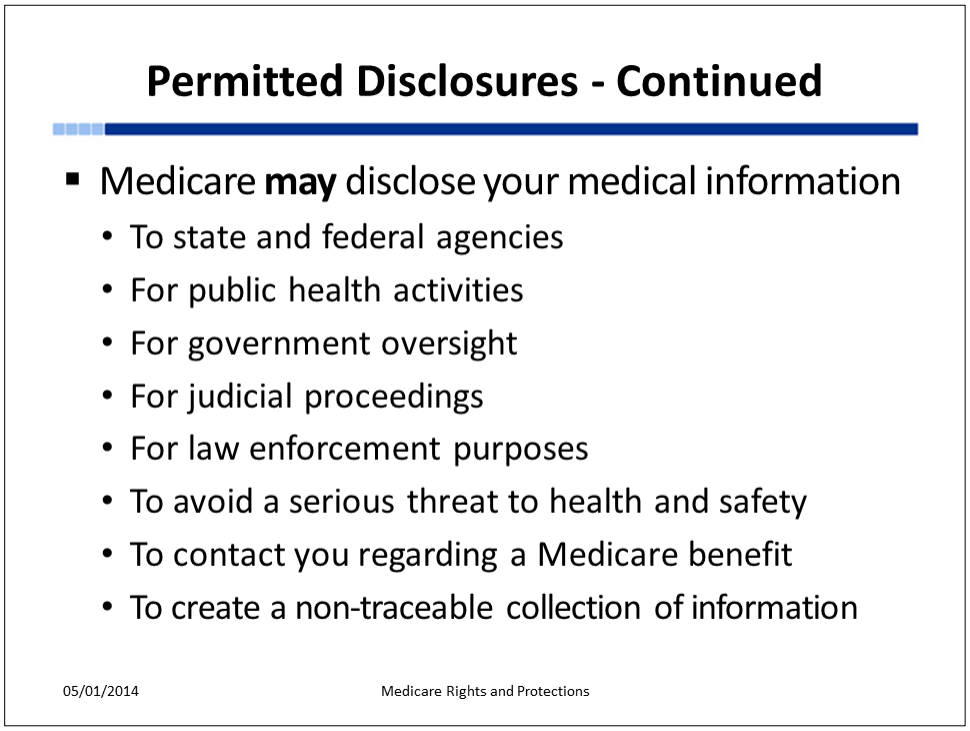
- To you or someone who has the legal right to act for you (your personal representative)
- To the Secretary of Health and Human Services, if necessary, to make sure your privacy is protected
- When required by law



Medicare may use and give out your personal medical information to pay for your health care and to operate the Medicare Program.

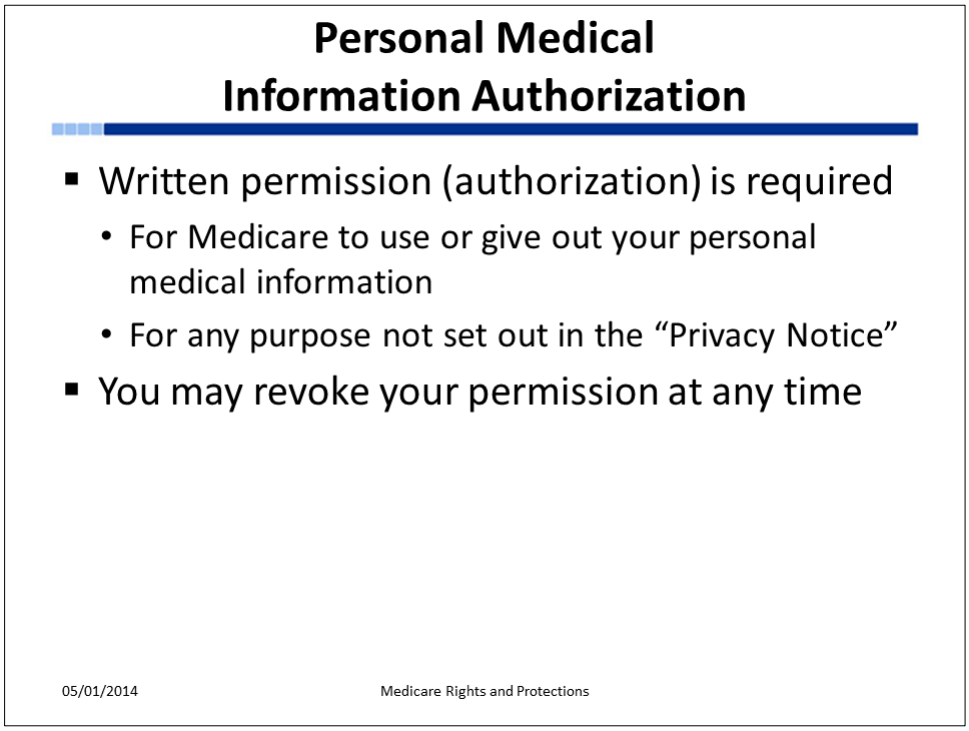
Medicare contractors use your personal medical information to pay or deny your claims, to collect your premiums, to share your benefit payment with your other insurer(s), and to prepare your Medicare Summary Notice.

Medicare may use your personal medical information to make sure you and other people with Medicare get quality health care, to provide customer services to you, to resolve any complaints you have, or to contact you about research studies.

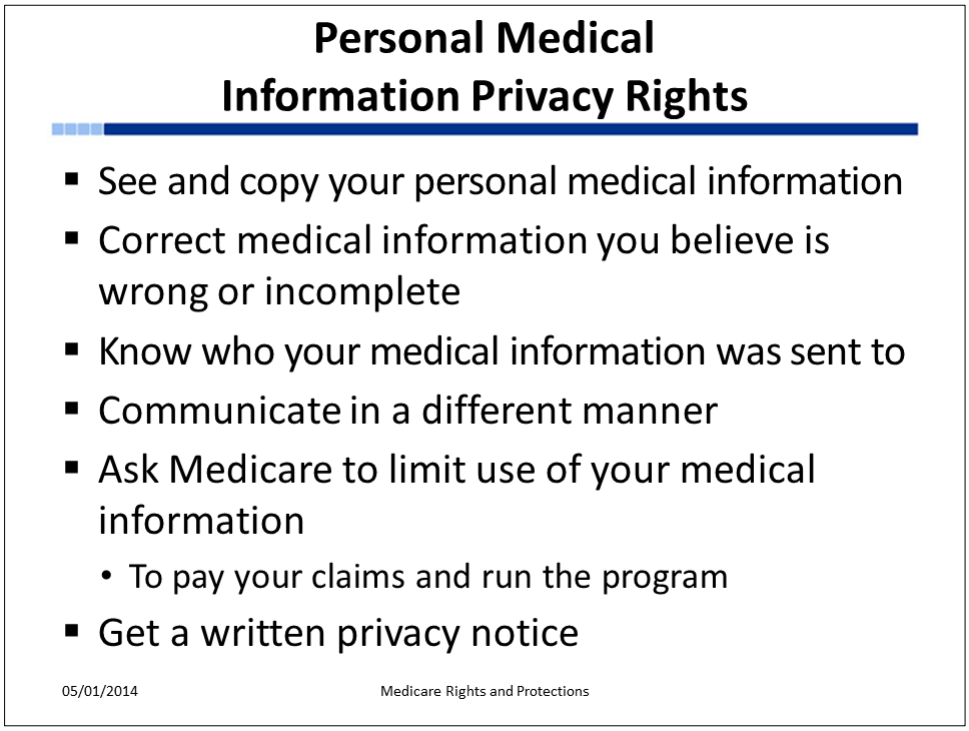


Medicare also may use or give out your personal medical information for the purposes shown here, under limited circumstances:

- To state and other federal agencies that have the legal right to receive Medicare data (such as to ensure Medicare is making proper payments and to assist federal/state Medicaid programs)
- For public health activities (such as reporting disease outbreaks)
- For government health care oversight activities (such as fraud and abuse investigations)
- For judicial and administrative proceedings (such as in response to a court order)
- For law enforcement purposes (such as providing limited information to locate a missing person)
- To avoid a serious threat to health or safety
- To contact you regarding a new or changed Medicare benefit
- To create a collection of information that can no longer be traced back to you



By law, Medicare must have your written permission (an "authorization") to use or give out your personal medical information for any purpose that isn't set out in this notice. You may take back ("revoke") your written permission at any time, except if Medicare has already acted based on your permission.



You have the following privacy rights. You may

- See and copy your medical information held by Medicare.
- Correct any incorrect or incomplete medical information.
- Find out who received your medical information for purposes other than paying your claims, running the Medicare Program, or for law enforcement.
- Ask Medicare to communicate with you in a different manner (e.g., by mail versus by phone) or at a different place (for example, by sending materials to a P.O. Box instead of your home address).
- Ask Medicare to limit how your personal medical information is used and given out to pay your claims and run the Medicare program. Please note that Medicare may not be able to agree to your request.
- Ask for a separate paper copy of these privacy practices.
    - If you want information about the privacy rules, call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

Need more information?

If you want information about the privacy rules,
call 1-800-MEDICARE (1-800-633-4227).
TTY users should call 1-877-486-2048.

If you believe Original Medicare has violated your privacy rights, you may file a complaint.

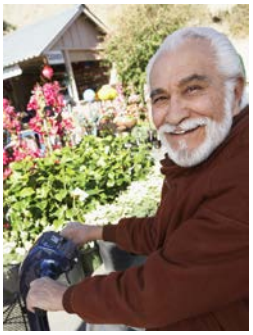
You can file a complaint by

- Calling 1-800-MEDICARE (1-800-633-4227) and asking to speak with a customer service representative. TTY users should call 1-877-486-2048.
- Contacting the U.S. Department of Health and Human Services Office for Civil Rights at hhs.gov/ocr/hipaa or by calling 1-866-627-7748. TTY users should call 1-800-537-7697.

Your complaint won't affect your benefits under Medicare.

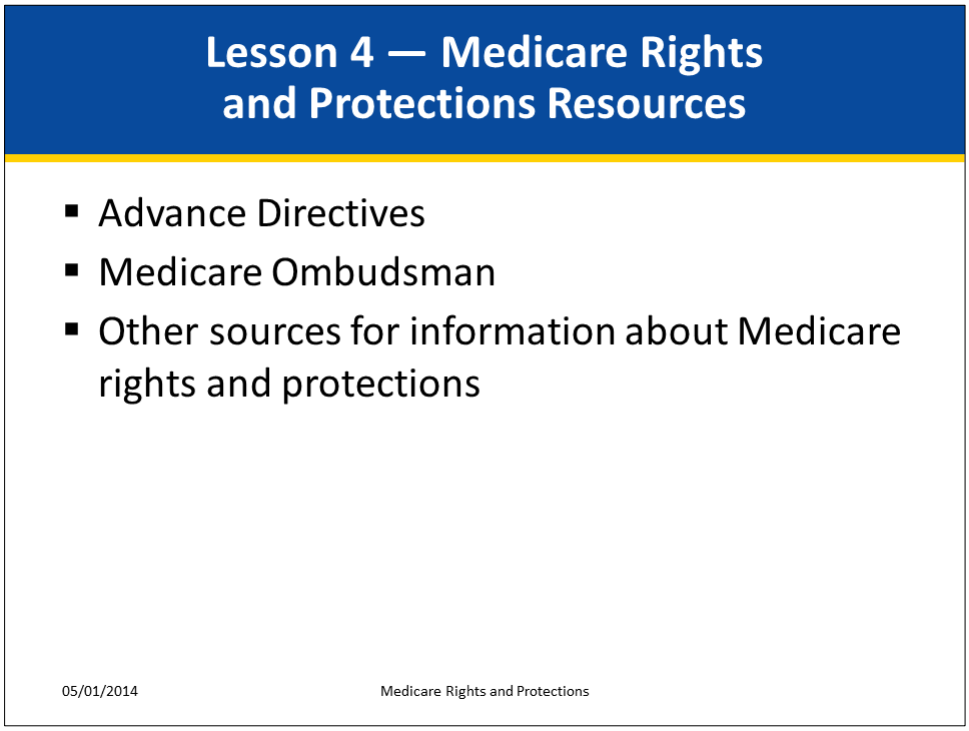
Check Your Knowledge—Question 7

Medicare may disclose your medical information at will, in whole or part, for any purpose.



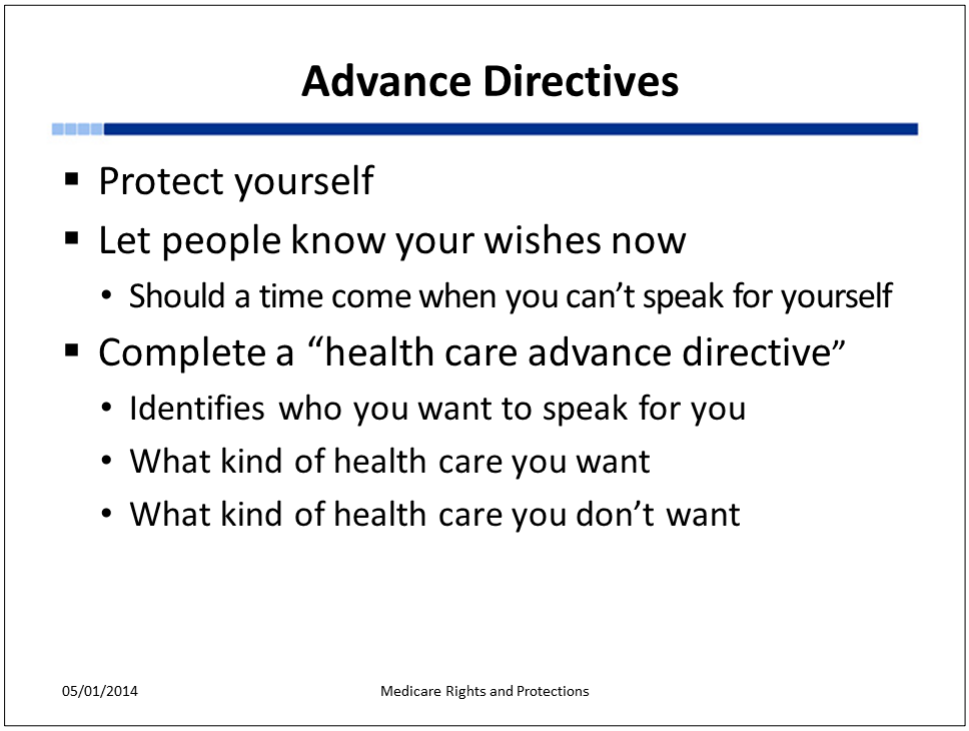
a. True
b. False

Refer to page 69 to check your answers.



Lesson 4, "Medicare Rights and Protections Resources," explains other relevant information and resources that are available to help you find information about your Medicare rights and protections.

- Advance Directives
- Medicare Ombudsman
- Other sources for information about Medicare rights and protections



As people live longer, there is a greater chance that they may not be able to make their own health care decisions at some point in time. Alzheimer's and other diseases affect your ability to make health care decisions.

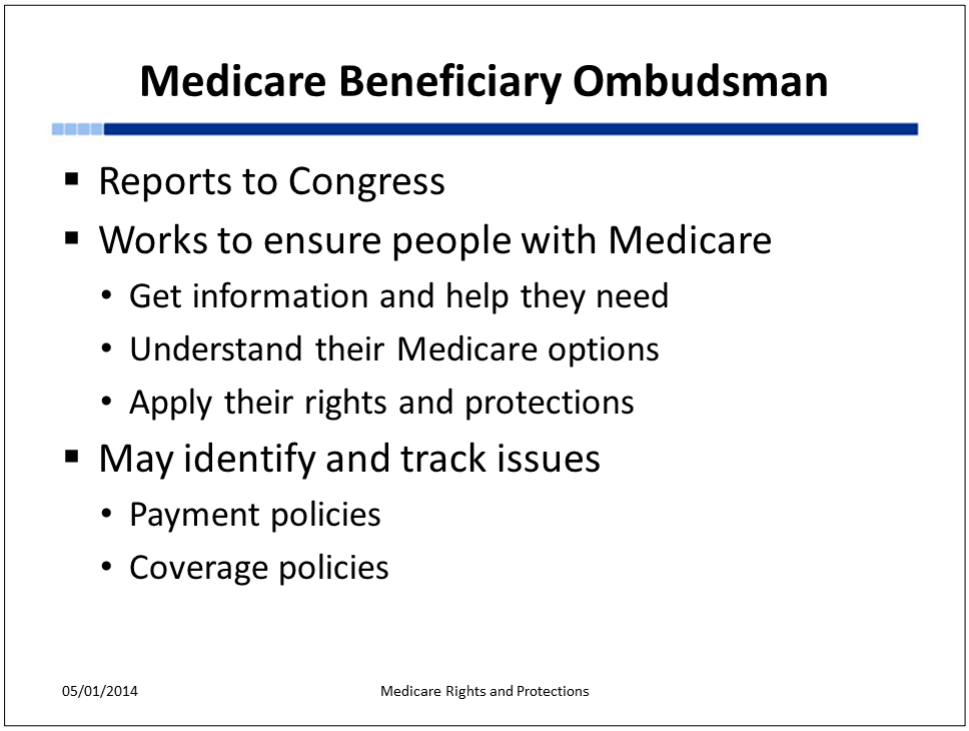
Making future health care decisions is another health care protection available to anyone, not just people with Medicare. Check for your state's requirements.

Advance directives are legal documents that allow you to put in writing what kind of health care you would want if you were too ill to speak for yourself. Advance directives most often include a health care proxy (durable power of attorney), a living will, and after-death wishes.

Talking with your family, friends, and health care providers about your wishes is important, but these legal documents ensure your wishes are followed. It's better to think about these important decisions before you're ill or a crisis strikes.

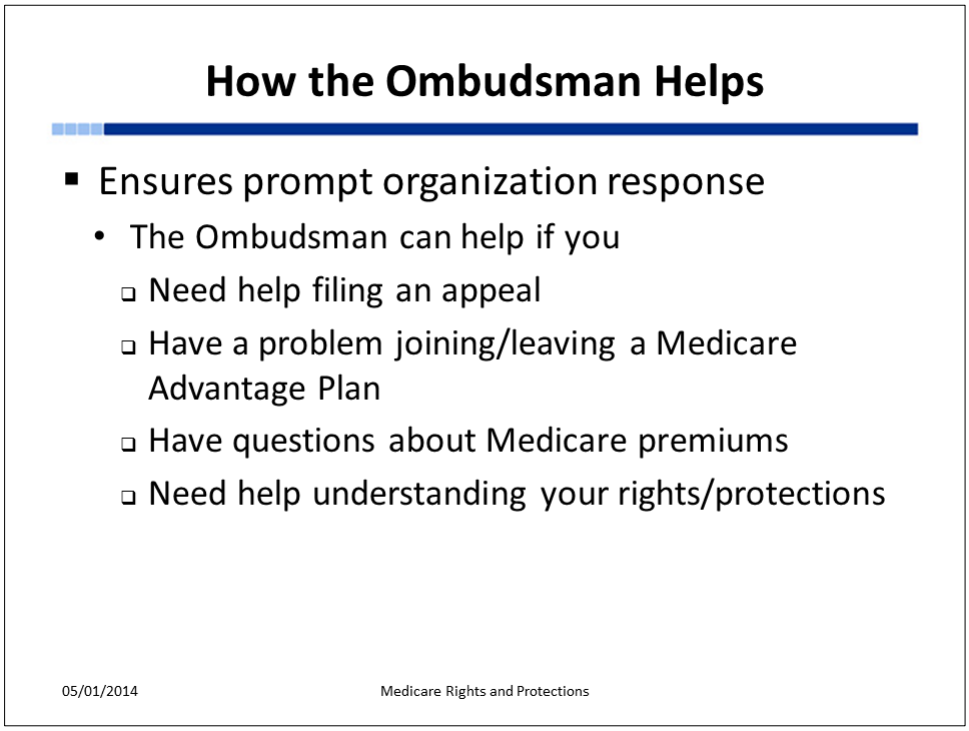
A health care proxy (sometimes called a durable power of attorney for health care), is used to name the person you wish to make health care decisions for you if you aren't able to make them yourself. Having a health care proxy is important because if you suddenly aren't able to make your own health care decisions, someone you trust will be able to make these decisions for you.

A living will is another way to make sure your voice is heard. It states which medical treatment you would accept or refuse if your life is threatened. For example, dialysis for kidney failure, a breathing machine if you can't breathe on your own, cardiopulmonary resuscitation (CPR) if your heart and breathing stop, or tube feeding if you can no longer eat.



Another protection for people with Medicare is the Medicare Beneficiary Ombudsman, commonly called "Ombudsman." The Ombudsman program office reports to Congress and works to ensure that people with Medicare get the information and help they need to understand their Medicare options and to apply their rights and protections.

The Ombudsman may identify and track issues and problems in payment and coverage policies, but doesn't advocate for any increases in program payments or new coverage of services.



The Ombudsman works to make sure the organizations that should help you with your complaints, appeals, grievances, or questions about Medicare work the way they should, and respond to you promptly.

For example, the Ombudsman can help if you

- Need help to file an appeal
- Have a problem joining or leaving a Medicare Advantage Plan (like a Health Maintenance Organization or Preferred Provider Organization) or other Medicare health plan, or a Medicare Prescription Drug Plan
- Have questions about Medicare premiums
- Need help understanding your Medicare rights and protections

Check Your Knowledge—Question 8

A living will is a legal document used to name the person you wish to make health care decisions for you if you aren't able to make them yourself.

a. True
b. False

Refer to page 69 to check your answers.

Medicare Rights and Protections Resource Guide

Resources

Centers for Medicare & Medicaid Services (CMS)
1-800-MEDICARE
(1-800-633-4227)
(TTY 1-877-486-2048)
medicare.gov

medicare.gov/get-help/ombudsman

medicare.gov/claims-and-appeals

cms.gov/bni
(Beneficiary Notice Initiative)

Department of Health and Human Services Office for Civil Rights
hhs.gov/ocr/office/index.html
1-866-627-7748
1-800-537-7697 for TTY users

05/01/2014

State Quality Improvement Organization *

Independent Review Entity (Medicare Advantage & Part D claims only) *

State Health Insurance Assistance Programs *

U.S. Railroad Retirement Board
rrb.gov

hhs.gov

Medicare Managed Care Manual, Chapter 13, Beneficiary Grievances, Organization Determinations, and Appeals:
cms.gov/regulations-and-guidance/guidance/manuals/downloads/mc86c13.pdf

*For telephone numbers, call CMS
1-800-MEDICARE (1-800-633-4227)
1-877-486-2048 for TTY users

Medicare Products

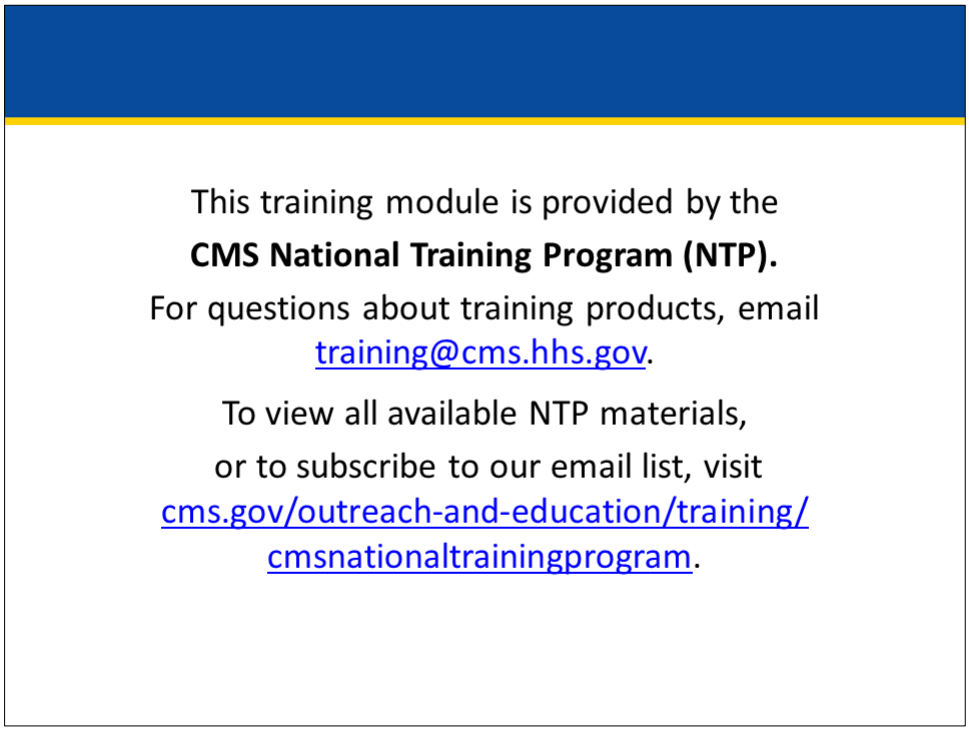
"Medicare & You Handbook"
CMS Product No. 10050

"Medicare Rights & Protections"
CMS Product No. 11534

To access these products:

View and order single copies at medicare.gov.

Order multiple copies (partners only) at productordering.cms.hhs.gov. You must register your organization.



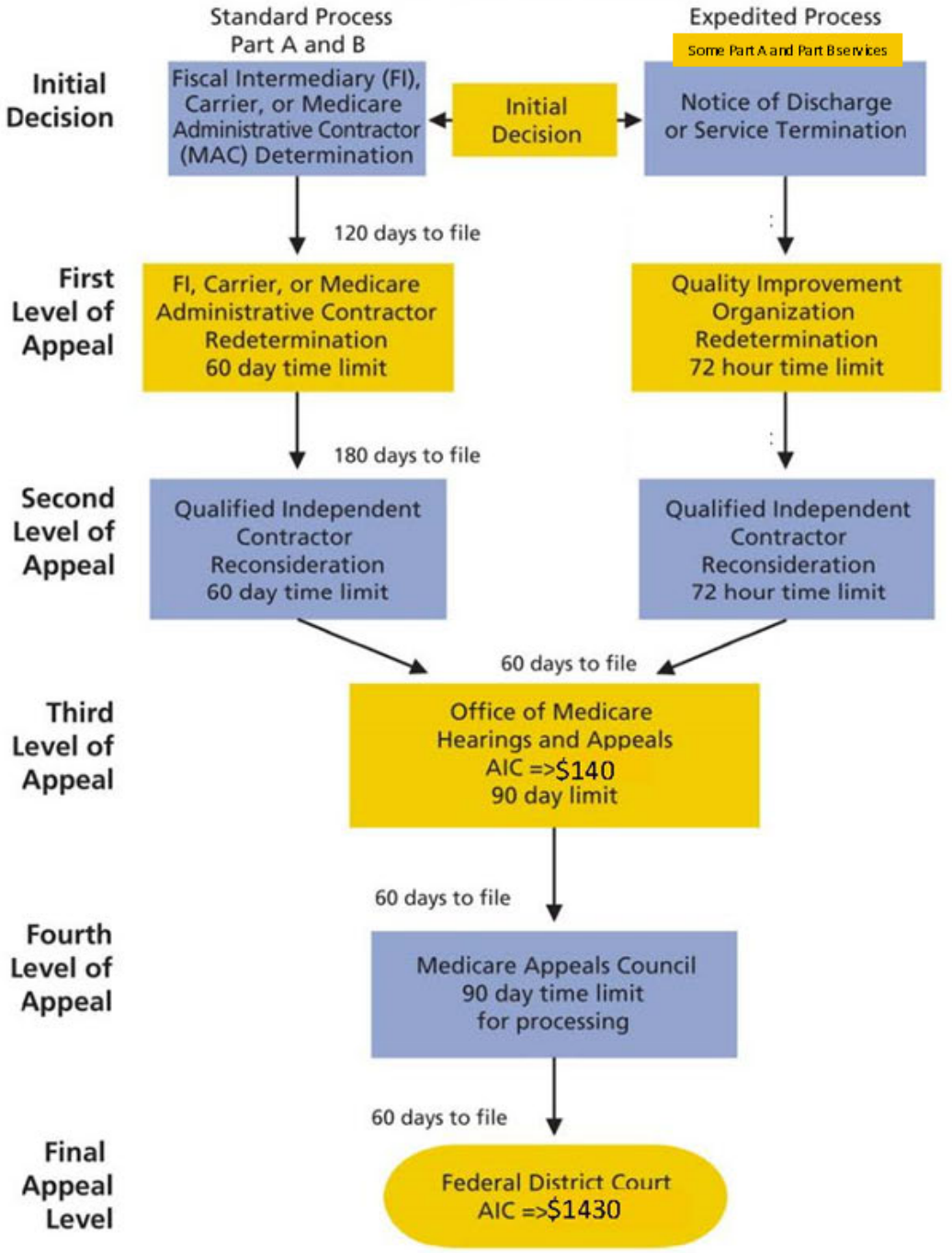
This training module is provided by the CMS National Training Program (NTP).

For questions about training products, email training@cms.hhs.gov.

To view all available CMS NTP materials or to subscribe to our email list, visit cms.gov/outreach-and-education/training/cmsnationaltrainingprogram.

Appendix A

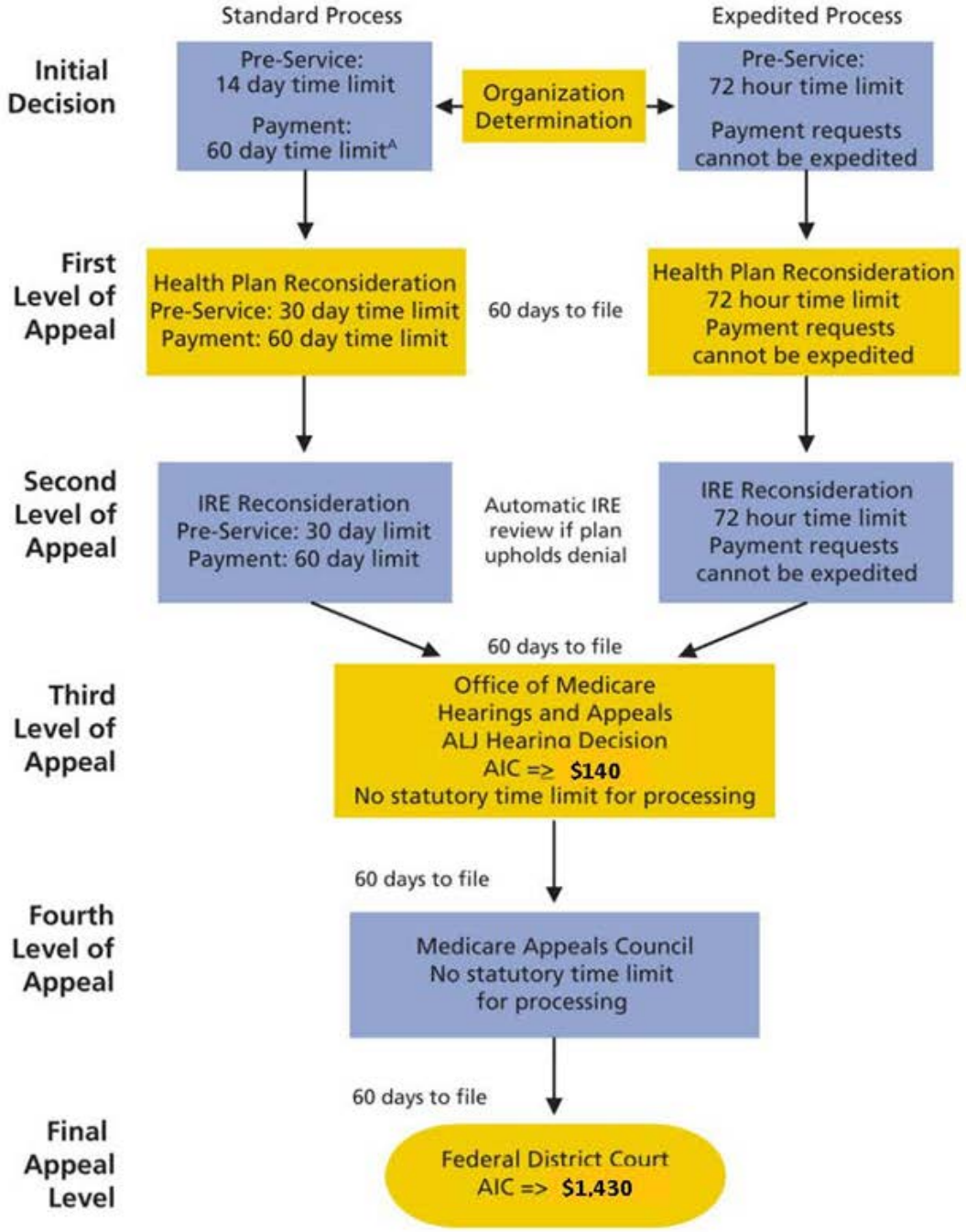
Parts A & B (Fee-for-Service) Process



AIC = Amount in Controversy MA-PD = Medicare Advantage Prescription Drug A: Plans must process 95% of all clean claims for out-of-network providers within 30 days. All other claims must be processed within 60 days. ALJ = Administrative Law Judge MMA = Medicare Prescription Drug, & The AIC requirement for all ALJ hearing and federal District Court is adjusted annually in accordance with the medical care component of the Consumer Price Index. The chart reflects the CY2014 AIC amounts. Contractor = fiscal Intermediary, Carrier or Improvement & Modernization Act of 2003 C: A request for a coverage determination includes a request for a tiering exception or a formulary exception. A request for a coverage determination may be filed by the enrollee, the enrollee's appointed representative, Medicare Administrative Contractor (MAC) PDP = Prescription Drug Plan or the enrollee's physician. The adjudication timeframes generally begin when the request is received by the plan sponsor. However, if the request involves an exception request, the adjudication timeframe begins IRE = Independent Review Entity QIC = Qualified Independent Contractor when the plan sponsor receives the physician's supporting statement.

Appendix B

Part C (MA) Process



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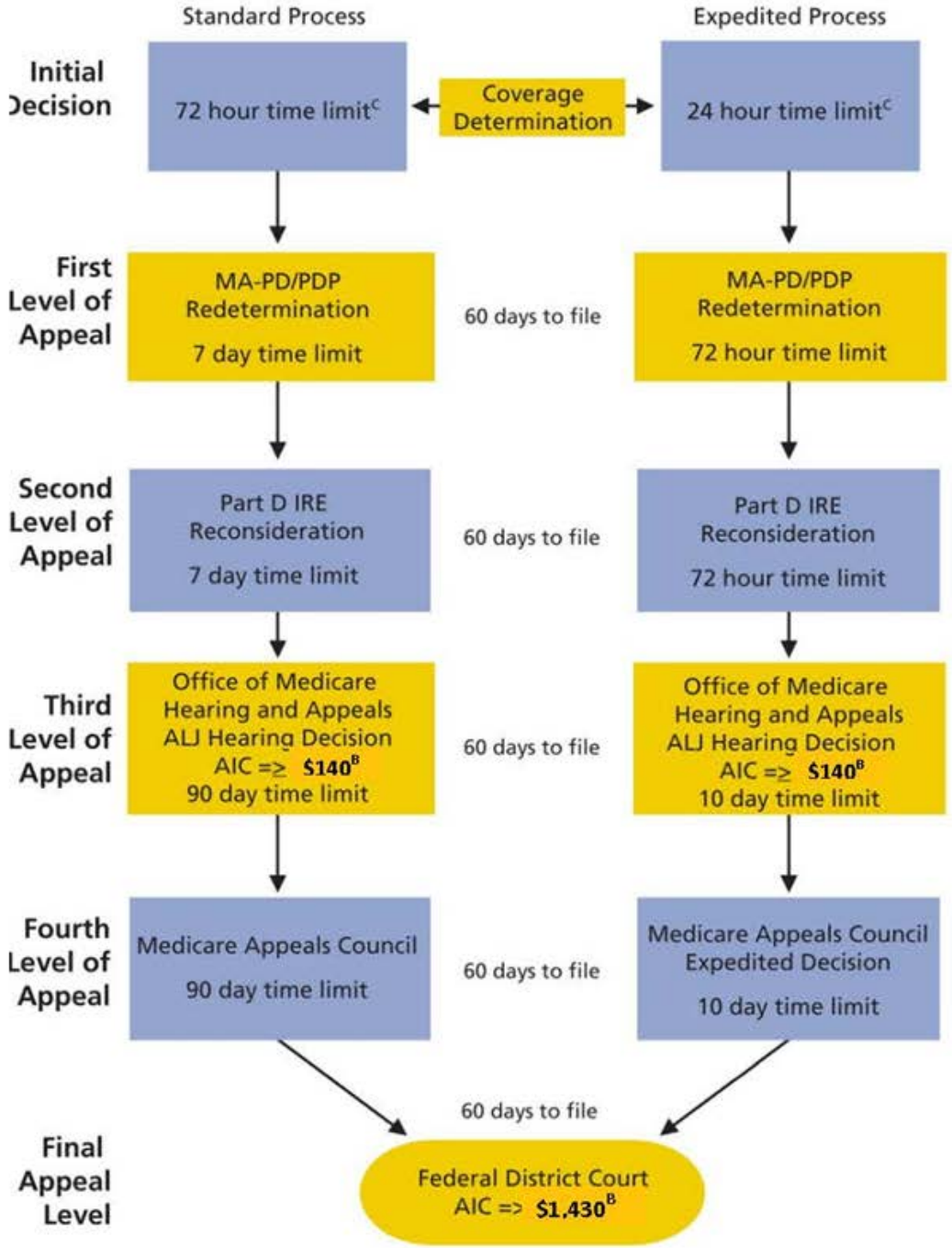
Appendix C

Part D (Drug) Process



AIC = Amount in Controversy MA-PD = Medicare Advantage Prescription Drug A: Plans must process 95% of all clean claims for out-of-network providers within 30 days. All other claims must be processed within 60 days. ALJ = Administrative Law Judge MMA = Medicare Prescription Drug, B: The AIC requirement for all ALJ hearing and federal District Court is adjusted annually in accordance with the medical care component of the Consumer Price Index. The chart reflects the CY 2014 AIC amounts. Contractor = Fiscal Intermediary, Carrier or Improvement & Modernization Act of 2003 C: A request for a coverage determination includes a request for a tiering exception or a formulary exception. A request for a coverage determination may be filed by the enrollee, the enrollee's appointed representative, Medicare Administrative Contractor (MAC) PDP = Prescription Drug Plan or the enrollee's physician. The adjudication time frames generally begin when the request is received by the plan sponsor. However, if the request involves an exception request, the adjudication time frame begins IRE = Independent Review Entity QIC = Qualified Independent Contractor when the plan sponsor receives the physician's supporting statement.

Appendix D

A. Notifier:

B. Patient Name: **C. Identification Number:**

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If Medicare doesn't pay for **D.** _____ below, you may have to pay. Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the **D.** _____ below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the **D.** _____ listed above.
  Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. OPTIONS: Check only one box. We cannot choose a box for you.

☐ **OPTION 1.** I want the **D.** _____ listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but **I can appeal to Medicare** by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ **OPTION 2.** I want the **D.** _____ listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed.**

☐ **OPTION 3.** I don't want the **D.** _____ listed above. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if Medicare would pay.**

H. Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY:** 1-877-486-2048). Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature:	J. Date:

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0566. The time required to complete this information collection is estimated to average 7 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.

Form CMS-R-131 (03/11) Form Approved OMB No. 0938-0566

Check Your Knowledge Answer Key

Question 1 (page 10)

All people with Medicare have the right to be protected from discrimination based on race, color, national origin, disability, age, sex and which of the following?

Answer: a

a. Religion. All people with Medicare have the right to be treated with dignity and respect at all times. Discrimination is against the law. Every company or agency that works with Medicare must obey the law, and can't treat you differently because of your

- Race, color, or national origin
- Disability
- Age
- Religion
- Sex

Question 2 (page 11)

An appeal and a grievance are the same thing.

Answer: b

b. False. People with Medicare have the right to file an appeal or a grievance, but they aren't the same thing. An appeal is a process used if you disagree with a decision about your health care payment, coverage of services, and prescription drug coverage.

A grievance is a formal complaint about the services you got, other concerns or problems you have in getting health care, and the quality of the health care you received.

Question 3 (page 20)

The Advance Beneficiary Notice of Non-coverage (ABN) is required to be used by all providers for all non-covered Original Medicare Services.

Answer: b

b. False. Doctors and suppliers aren't required to give you an ABN for services Medicare never covers, (i.e., excluded under Medicare law), such as routine eye exams, dental services, hearing aids, and routine foot care, although they may voluntarily give you an ABN for items and services excluded by Medicare as a courtesy.

Question 4 (page 25)

If you join a Medicare Advantage (MA) Plan, you have fewer rights than in Original Medicare when making an appeal.

Answer: b

b. False. If you join a Medicare Health Plan like an MA Plan, although the appeals process is a little different, you still have all of the rights, privileges, and protections that are afforded to you in Original Medicare. You still have the same rights to file appeals and grievances.

Question 5 (page 41)

A drug plan must respond to a standard coverage determination request for medication within

Answer: b

b. 72 hours. Plans must provide a notice at the pharmacy counter whenever a prescription isn't filled as written, and plans must provide a notice after every coverage determination.

A plan must give you its coverage determination decision as quickly as your health condition requires. After getting your request, the plan must give you its decision no later than 72 hours for a standard determination, or 24 hours for an expedited determination. If your coverage determination request involves an exception, the time clock starts when the plan gets your doctor's supporting statement.

Question 6 (page 46)

The "Important Message From Medicare" is an optional notice provided to a person with Medicare who is admitted to the hospital at the hospital's discretion.

Answer: b

b. False. The "Important Message From Medicare" is a required notice you receive after being admitted to the hospital. This notice is signed by you, and a copy is provided to you explaining your rights to

- Get all medically-necessary hospital services
- Be involved in any decision(s)
- Get services you need after you leave the hospital
- Appeal discharge decision and steps for appealing decision
- Circumstances in which your hospital services may be paid for during the appeal

Question 7 (page 55)

Medicare may disclose your medical information at will, in whole or part, for any purpose.

Answer: b

b. False. By law, Medicare must have your written permission (an "authorization") to use or give out your personal medical information for any purpose that isn't set out in the "Notice of Privacy Practices for Original Medicare." You may take back ("revoke") your written permission at any time, except if Medicare has already acted based on your permission.

Medicare may use and give out your personal medical information to pay for your health care and to operate the Medicare program.

Medicare contractors use your personal medical information to pay or deny your claims, to collect your premiums, to share your benefit payment with your other insurer(s), and to prepare your Medicare Summary Notice.

Medicare may use your personal medical information to make sure you and other people with Medicare get quality health care, to provide customer services to you, or to resolve any complaints you have, or to contact you about research studies.

Question 8 (page 60)

A living will is a legal document used to name the person you wish to make health care decisions for you if you aren't able to make them yourself.

Answer: b

b. False. A living will is a way to make sure your voice is heard. It states which medical treatment you would accept or refuse if your life is threatened. For example, dialysis for kidney failure, a breathing machine if you can't breathe on your own, cardiopulmonary resuscitation if your heart and breathing stop, or tube feeding if you can no longer eat.

A health care proxy, sometimes called a durable power of attorney for health care, is used to name the person you wish to make health care decisions for you if you aren't able to make them yourself. Having a health care proxy is important because if you suddenly aren't able to make your own health care decisions, someone you trust will be able to make these decisions for you.

Acronyms

ABN	Advance Beneficiary Notice of Non-coverage
AIDS	Acquired Immune Deficiency Syndrome
ALJ	Administrative Law Judge
CMS	Centers for Medicare & Medicaid Services
CHIP	Children's Health Insurance Program
ESRD	End-Stage Renal Disease
HIV	Human Immunodeficiency Virus
IRE	Independent Review Entity
MA	Medicare Advantage
MAC	Medicare Appeals Council
MSN	Medicare Summary Notice
NTP	National Training Program
OCR	Office for Civil Rights
PHI	Personal Health Information
QIC	Qualified Independent Contractor
QIO	Quality Improvement Organization
SHIP	State Health Insurance Assistance Program
TTY	Teletypewriter

Index

Website: cms.gov/outreach-and-education/training/cmsnationaltrainingprogram

Email: training@cms.hhs.gov

Centers for Medicare & Medicaid Services

7500 Security Boulevard
Baltimore, MD 21244